Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report August 27, 2019

Auditor Information

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Company Name: Office of the Independent Ombudsman	
Mailing Address: 11209 Metric Blvd., Bldg. H, Suite A	**City, State, Zip:** Austin, Texas 78758
Telephone: 512-490-7971	**Date of Facility Visit:** June 12-13, 2019

Agency Information

Name of Agency Texas Juvenile Justice Department		**Governing Authority or Parent Agency** *(If Applicable)* Click or tap here to enter text.	
Physical Address: 11209 Metric Blvd., Bldg. H, Suite A		**City, State, Zip:** Austin, Texas 78758	
Mailing Address: 11209 Metric Blvd., Bldg. H, Suite A		**City, State, Zip:** Austin, Texas 78758	
Telephone: 512-490-7130		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Agency mission: Transforming young lives and creating safer communities			
Agency Website with PREA Information: https://www.tjjd.texas.gov/programs/prea.aspx			

Agency Chief Executive Officer

Name: Camille Cain	**Title:** Executive Director
Email: camille.cain@tjjd.texas.gov	**Telephone:** 512-490-7004

Agency-Wide PREA Coordinator	
Name: Carla Bennett-Wells	**Title:** PREA Coordinator
Email: Carla.Bennett.Wells@tjjd.texas.gov	**Telephone:** 254-297-8200
PREA Coordinator Reports to: Terri Dollar	**Number of Compliance Managers who report to the PREA Coordinator** 12

Facility Information				
Name of Facility: Cottrell House				
Physical Address: 7929 Military Parkway Dallas, Texas 75227				
Mailing Address (if different than above): Click or tap here to enter text.				
Telephone Number: 214-388-5497				
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☒ State	☐ Federal	
Facility Type:	☐ Detention	☒ Correction	☐ Intake	☐ Other
Facility Mission: Transforming young lives and creating safer communities.				
Facility Website with PREA Information: https://www.tjjd.texas.gov/programs/prea.aspx				
Is this facility accredited by any other organization? ☐ Yes ☒ No				

Facility Administrator/Superintendent	
Name: Marketa Johnson	**Title:** Superintendent
Email: marketa.johnson@tjjd.texas.gov	**Telephone:** 214-388-5497

Facility PREA Compliance Manager	
Name: Phillip Jones	**Title:** Assistant Superintendent / PREA Compliance Manager
Email: phillip.jones@tjjd.texas.gov	**Telephone:** 214-388-5497

Facility Health Service Administrator	
Name: Stacy Gaston	**Title:** Registered Nurse
Email: sjgaston@utmb.edu	**Telephone:** 940-665-0701

Facility Characteristics		
Designated Facility Capacity: 24	**Current Population of Facility:** 16	
Number of residents admitted to facility during the past 12 months		88
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:		88
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:		88
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:		0
Age Range of Population:	14 - 18	
Average length of stay or time under supervision:		74 days
Facility Security Level:		Medium
Resident Custody Levels:		Medium
Number of staff currently employed by the facility who may have contact with residents:		21
Number of staff hired by the facility during the past 12 months who may have contact with residents:		4
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		3

Physical Plant	
Number of Buildings: 1	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	6
Number of Segregation Cells (Administrative and Disciplinary:	0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

A video monitoring system with 36 interior and 18 exterior cameras located throughout the house augments the facility's zero-tolerance efforts. Since the last PREA Audit, no additional cameras or related devices were installed. Video is stored for 60 – 90 days. While on site, the auditor viewed live feed of several cameras, which indicated sufficient coverage of all areas except one potential blind spot outside, which the Assistant Superintendent pointed out during the facility inspection. He and the PREA Compliance Coordinator said that this area was noted on the annual vulnerability assessment and facility staff members had been alerted and instructed to position themselves toward this area when residents were outside. Additionally, the current Safe Housing Staffing Plan includes the number of cameras located in each area and a description of the one blind spot in the backyard area.

Entrance to the house is restricted, as the front door is locked. Visitors use a doorbell to notify a staff member assigned to the reception area, identify themselves, enter a waiting area, sign the visitor's log, place car keys in a locked box, and are screened with a handheld metal detector. These procedures were utilized when the auditor team arrived on site.	
Medical	
Type of Medical Facility:	Hospital
Forensic sexual assault medical exams are conducted at:	Parkland Hospital
Other	
Number of volunteers and individual contractors who may have contact with residents, currently authorized to enter the facility:	20
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

Introduction

The Prison Rape Elimination Act (PREA) audit of Cottrell House (Cottrell), a medium-restriction facility operated by the Texas Juvenile Justice Department (TJJD), is located Dallas, Texas. The auditor team included two Department of Justice Certified PREA auditors and one non-certified auditor. Nicole Prather was the lead and point of contact throughout the audit with Dwight Sadler and Allen Wallace assisting. The on-site portion of the audit occurred on
June 12 – 13, 2019.

This was the second audit of the facility; the first occurred March 2-3, 2016. During the corrective action period of the first audit, the facility implemented six corrective actions to become fully PREA compliant. The previous auditor noted in the final report dated August 1, 2106 that Cottrell took corrective actions regarding the documentation of unannounced rounds and amending the facility coordinated response to be specific to Cottrell. Corrective actions requested at the agency level included modifying the agency's screening tool, providing documentation of PREA-related training for agency investigators.

For the 2019 audit, the auditor team consisted of ombudsmen employed by the Office of the Independent Ombudsman (OIO) for TJJD. A memorandum of understanding (MOU) between the OIO and the TJJD was executed on May 21, 2018 and became effective on June 1, 2018. The MOU stipulates that the Ombudsman will conduct audits of TJJD-operated facilities in accordance with the PREA and requires that TJJD shall reimburse the Ombudsman for travel expenses, including lodging, meals, and mileage, incurred by the Ombudsman in the course of conducting the audits. Once the MOU was effective, the OIO and the TJJD began discussions regarding potential dates for the audits during this audit cycle. Once the dates for each audit were determined, the lead auditor began preliminary discussions. No third-party entity was involved in the audit process.

No barriers hindered the audit process, and the auditor was provided documentation uploaded to a secure common drive for an initial review. The documents were organized into folders that corresponded to each PREA Standard. Additional phone calls and emails were shared with the facility Assistant Superintendent/PREA Compliance Manager and PREA Compliance Coordinator, which are discussed below in the Pre-Audit phase. During the on-site portion of the audit, the auditor was granted full access to the following:

1. Staff members and youth who were selected to be interviewed prior to the on-site portion of the audit
2. Youth and staff members during informal interviews during the facility inspection
3. All areas in and outside of the facility including closets, offices, individual rooms, restrooms, and storage areas
4. Relevant documents requested prior to the on-site audit, during the audit, following the audit, and during the corrective action period

The audit process was discussed with the Assistant Superintendent and Compliance Coordinator through emails and phone calls. All understood that the purpose of the audit was to determine compliance with each PREA Standard and that to make determinations, the auditor would need access to supporting documentation, staff and youth, and all areas of the house. The facility provided each of these, and the auditor determined corrective actions that would enhance current practices, policy and documentation, and staff and youth knowledge and understanding of the PREA Standards. The auditor discussed the corrective actions and interim and final reports timelines with the Compliance Manager and the Assistant Superintendent during a brief exit meeting.

Pre-Audit

Pre-audit preparation included sending the PREA audit notification to the facility Assistant Superintendent and verifying the notices were posted at least six weeks prior to the audit and included necessary contact information. The Assistant Superintendent provided photographs of the notices throughout the facility, which confirmed they were posted on brightly colored paper, at least six weeks prior to the audit and contained the required information. The notices stated that correspondence with the auditor would have been confidential had it been utilized. The auditor received no correspondence from Cottrell youth or staff.

The Pre-Audit Questionnaire (PAQ) was initiated once the TJJD PREA audit schedule was confirmed on April 10. On June 7, the upload to a secure agency drive was completed and included the PAQ, TJJD policies, TJJD and facility procedures, and documentation supporting compliance with each standard. The auditor reviewed the PAQ, policies, and other documents including organizational charts, mission statement, protocols, staffing plans, various contracts, and training curricula specific to each standard. Questions and requests for clarification and additional information were listed in the comments section by standard in an issues log, which was emailed to the facility Assistant Superintendent and Compliance Coordinator. Responses were typed within the document and additional information was uploaded to the secure drive.

An initial phone call was held with the lead auditor, Assistant Superintendent and Compliance Manager, and Interim Compliance Coordinator on April 22, 2019. Items discussed included the following:

1. Logistics regarding the size of the auditor team, number of private spaces needed during interviews, requirement to interview staff members from all shifts, and space needed to review documentation on site
2. Audit process and purpose including entrance meeting, triangulation, report requirements, observations and informal interviews during facility inspection
3. Goals and expectations such as becoming fully PREA compliant, collaboration, and having access to documents, staff members, all areas of the house, and youth
4. Purpose of corrective actions such as enhancing current practices and providing sexual safety to youth and staff
5. Schedule of future communication including the issues log, follow-up phone calls, staff and youth lists, confirmation of on-site audit arrival and estimated departure times

6. Timelines and milestones including issue log, interim report due date, and corrective action period

Following the call, the Audit Process Map and Checklist of Policies/Procedures were sent to each participant via email.

On May 28, a document containing the required categories of staff members and youth was emailed to the Assistant Superintendent and Compliance Manager, which was completed and sent to the auditor via email the following day. The list also included staff members who were interviewed in person or by telephone prior to the on-site portion of the audit. Staff members representing each of the specialized designations and each shift, two volunteers, and one contractor were included. Additional details are below in the On-Site section.

The requested staff member designations included:

- Superintendent
- Compliance Manager/Coordinator
- Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds
- Medical staff
- Mental health staff
- Non-medical staff involved in cross-gender strip or visual searches
- Administrative/Human Resources staff
- Volunteers who have contact with residents
- Contractors who have contact with residents
- Investigative staff
- Staff who perform screening for risk of victimization and abusiveness
- Staff on the sexual abuse incident review team
- Designated staff member charged with monitoring for retaliation
- First responders including security and non-security staff
- Intake Staff

The youth tables were organized into each of the National PREA Resource Center's prescribed targeted populations as follows:

- Youth with disabilities (i.e., physical disabilities, blind, deaf, hard of hearing, cognitive disabilities)
- Youth who are Limited English Proficient (LEP)
- Lesbian, gay, bisexual, transgender and intersex (LGBTI) youth
- Youth who reported sexual abuse
- Youth who reported sexual victimization during risk screening
- Youth in isolation

No youthful offenders' names were requested, as Cottrell does not serve this population.

In addition to the facility youth list, the auditor printed a youth population report from TJJD's intranet that included the youth's ethnicity, special education status, limited English proficiency status, and age. The facility indicated that no youth fell into any of the target populations, but the population report printed by the auditor indicated that four youth received special education services, and one was limited English proficient. Additionally, prior to the on-site portion of the audit, the auditor reviewed the current and previous safe housing assessments of all youth assigned to the facility. At a previous TJJD facility, one youth reported prior sexual victimization during the screening that occurred at TJJD's Orientation and Assessment Unit. Twelve youth, including the one who reported prior victimization, those receiving special education services, and the one with limited English proficiency, were selected for interviews. Further details are included in the On-Site section below.

The list of selected youth, staff members, volunteers, and a contractor to be interviewed was sent via email to the PREA Compliance Manager the day before the on-site portion of the audit to ensure independent responses. Also included in the list were staff members who were interviewed prior to arriving on site.

The auditor was granted access to grievances/complaints, incidents, and allegations and hotline calls regarding sexual abuse/harassment for the 12 months preceding the audit. The Office of the Inspector General (OIG), the Administrative Investigation Division (AID), and the facility reported that no allegations of sexual abuse were received. Allegations may be received through hotline calls to the Incident Reporting Center (IRC), which is monitored by the OIG, written grievances, calling the OIO, or reporting verbally to a staff member, volunteer, or contract employee.

Prior to the audit, the auditor reviewed the MOU between Cottrell House and the Advocacy Center for Crime Victims & Children in Waco, Texas and interviewed the Executive Director of the crisis center who stated that she was unaware of an MOU with the facility. She described the services that would be provided; however, she said that the crisis center would not provide them to residents in Dallas, Texas where Cottrell is located because the distance would be a barrier.

No external investigators were interviewed for administrative investigations, as TJJD's AID conducts all such investigations. Although TJJD's organizational chart indicated that AID falls under the OIG division, AID's policy is outlined in TJJD's General Administrative Policy (GAP) and is considered an internal administrative investigative entity.

In previous PREA audits of TJJD facilities, the OIG was reported to be and considered an internal investigative entity. For audits during the previous audit cycle as well as this audit, the agency and OIG reported that although the OIG and TJJD are administratively associated, the OIG is a separate investigative entity. The Human Resources Code states that the OIG "is established at the department [TJJD] under the direction of the board for the purpose of investigating" crimes committed by TJJD employees and youth, and that "the inspector general shall have all the powers and duties given to peace officers…" The OIG website contains similar information as well as information on reporting to the IRC, quarterly and annual reports, and the special prosecution unit which was established to "assist District and County Attorney offices in the prosecution of criminal investigations conducted" by the OIG.

An Internet search of Cottrell yielded no articles from newspapers or other information regarding the facility.

The agency website includes the following PREA-related information, all of which is discussed in detail in the relevant standards.

- Policy governing sexual abuse/harassment
- Information on how to report alleged abuse or sexual harassment on behalf of a youth
- Toll-free hotline number
- Aggregated sexual abuse data from TJJD-operated and contracted facilities
- Historical sexual abuse data

The auditor viewed the website of Parkland Hospital, which was listed on the PAQ as the facility that would provide SAFE/SANE services for Cottrell youth. The website indicated these services are available.

The auditor viewed the Texas Department of Family and Protective Services (DFPS) website to verify the mandatory reporting laws. Texas has both civil and criminal laws to protect children from abuse and neglect and states, "If you suspect that a child is being abused or neglected, the law requires that you report it. [Texas Family Code Section 261.101 (a)]." TJJD policy requires that all staff to comply with mandatory child abuse reporting laws in Texas Family Code and meet applicable professional licensure requirements.

The auditor received no correspondence from youth or staff members of Cottrell prior to the on-site portion of the audit.

On-Site Audit

Upon arriving to the facility, the auditor met with the facility Assistant Superintendent/Compliance Manager, the agency Compliance Coordinator, and the facility Superintendent to further discuss the on-site portion of the audit and facility inspection. Cottrell is comprised of one house that contains six bedrooms that can accommodate up to four youth each, a day area, dining area, kitchen, offices, one room where education services are provided, bathrooms, and backyard with three storage buildings. Seventeen youth were assigned to one of the five bedrooms that were in use during the audit. During the inspection, consideration was given to camera placements and potential blind spots, the configuration of rooms, restroom and shower areas, programming activities, the level of youth supervision, indicators of any area lacking sufficient monitoring, and PREA notifications and posters. The Compliance Manager was aware of the one potential blind spot discussed above on page 3, described actions taken as a result, and said the blind spot was included in the facility's vulnerability assessment.

Processes observed during the on-site portion included youth and staff members entering and exiting the house, unstructured/leisure time, lunch, bathroom routines, and recreation. During each activity, Coaches were positioned so that line of sight and overall safety was maintained. Youth bathrooms are located outside of their individual rooms, provide privacy, and located so that supervision can be maintained. The facility requires opposite-gender staff members to announce their presence when entering the house. Youth and staff stated that female staff members consistently adhered to this

practice, which was corroborated during the inspection when the auditor team observed staff members of the opposite gender announcing themselves as they entered.

The facility does not contain a designated intake and process area as intake is conducted in a case manager's office. No new youth arrived during the audit, so the intake process was not observed. However, case managers and youth interviewed during the audit provided details of this process, which are discussed in the relevant standards below.

A locked grievance box was observed during the inspection, and grievance forms were available to all youth, which was confirmed during informal interviews with random youth and the Youth Grievance Clerk. Each stated they had access to locked box in which grievances may be placed. Informal interviews with youth and staff confirmed that the box remained locked and was checked daily. Grievance procedures, zero tolerance posters, OIO posters, youth and parent rights, and the audit notices were posted in prominent areas. Information about the typical staff-to-youth ratio was also gathered during informal interviews. Youth and staff stated a ratio of 1:8 during waking hours and 1:12 during sleeping hours was maintained. Additionally, youth stated they felt safe and that the level of supervision observed during the audit was typical. Additional information about TJJD's required ratios is discussed below in standard 115.313.

Youth and staff members said that unannounced rounds were frequently conducted, and youth stated supervisory staff members were consistently present and accessible. Documentation supporting these practices are discussed below in standard 115.313.

Formal interviews were conducted following the facility inspection on the afternoon of the first day, during the late-night shift, and on the morning of the second day. As listed above in the Pre-Audit section, the auditor team interviewed random, supervisory, and specialized staff representing different levels of seniority and authority assigned to all three shifts, medical and mental health care staff, agency and facility department heads, a contracted Alcohol and Other Drug counselor, and youth representing three categories of the PREA Resource Center's (PRC's) targeted populations. Most staff members serve in more than one role, and all staff members are potential first responders; therefore, more than one interview protocol was used for several staff members. Although twelve youth were preselected, 16 of the 17 youth assigned to the facility were interviewed, as all were present on the first day of the audit. One youth refused to be interviewed. Interviews took place in separate, private spaces inside the facility. Interviews conducted prior to the on-site audit included the Compliance Coordinator, Human Resources Administrator, Agency Head, one volunteer, the Director of Nursing of Gainesville State School, an AID investigator, OIG investigator, and the Agency Contract Administrator. The Director of the crisis center was interviewed by telephone after the on-site portion of the audit.

The interviewers used the National PREA Resource Center's Interview Protocols for Juvenile Facilities for guidelines and interview questions. Responses to questions regarding staff members' knowledge of PREA policies, reporting responsibilities, first responder and investigative duties, and training were compiled and integral to determining PREA compliance. Youths' responses to questions regarding their knowledge of PREA policies, the education and services they receive, and intake processes were also essential in determining compliance. During interviews, a mental health professional was available to provide services should youth need assistance after an interview, but no youth required or requested this service.

Interview totals were as follows. Additional details are included in the relevant standards below.

Interviewees	Total number at facility	Total Interviewed
Random staff	21	8
Specialized staff	Total not requested	19
Volunteers and contractors	20	2
Random youth	17	16
Disabled youth/receive special education	4	4
Youth with limited English proficiency	1	1
Youth who identify as LGBTI	0	0
Youth who reported sexual abuse	0	0
Youth placed in isolation	0	0
Youth who disclosed prior sexual victimization during risk screening	1	0
Young males (ages 10-15)	0	0

In addition to completing interviews, the second day of the on-site portion involved reviewing additional documentation for specific standards requested by the auditor. The intake records of all youth assigned to the facility were contained in a binder and reviewed on site to determine compliance with intake and PREA comprehensive education procedures. Two recently hired personnel records provided on site and the hire dates and background checks of one recently promoted employee, four facility employees, two volunteers, and one contracted counselor were reviewed to determine compliance with criminal background checks, disclosure of PREA Standards violations, reference checks, Child Abuse Registry checks, and acknowledgment forms from PREA annual and refresher trainings. Personnel files are discussed below in standard 115.317.

Additional documentation reviewed prior to and during the audit included the following items, with each item discussed below in the relevant standards.

- Organization charts
- Contracts for the confinement and care of youth
- Staffing plans
- Unannounced Visit forms

- Safe housing assessments and reassessments
- PREA education materials
- TJJD Youth Handbook
- TJJD Employee Handbook
- Notifications made to youth following an investigation
- Sexual Abuse Incident Review Form
- Facility map with camera numbers
- Training curricula and sign-in sheets
- Medical and mental health case notes
- Youth grievances
- Data collection instrument
- Retaliation monitoring forms
- Nursing protocols
- Vulnerability assessments

No investigative files were reviewed, as no PREA-related investigations were conducted during the previous 12 months. An OIG Management Analyst provided a statement indicating that three cases were initially reported as being PREA-related but after reviewing the incidents, the OIG concluded that this was an error due to the cases having been miscoded. The auditor reviewed one of these incidents from the IRC Complaint Manager. The incident occurred in the recreation yard where staff and youth were present. One youth pulled down the pants of another youth at which time the two youth were separated and the incident reported to the OIG and to facility supervisors. The Compliance Coordinator and AID investigator provided statements indicating there were no PREA-related administrative investigations conducted in the previous 12 months.

On the second day of the on-site audit, the auditor conducted a brief exit meeting to discuss overall PREA compliance, staff and youth knowledge of the PREA, and actions to be taken following the on-site portion with the Compliance Coordinator, Compliance Manager, and Superintendent.

Post On-Onsite Audit

Following the audit, the auditor team compiled facility inspection, interview, informal interview, and documentation data. Follow-up communications between the auditor and facility leadership requesting additional clarification or documentation were completed. On July 22, 2019 the lead auditor completed the interim PREA Audit Report indicating the compliance determinations for each standard and sent the report via email to the facility Compliance Coordinator, Compliance Manager, and Superintendent. Corrective action was requested for each unmet standard, which initiated the 180-day corrective action period. Communications between the auditor and PREA Coordinator via email, phone calls, and in-person meetings will be maintained throughout this period and documented in the final audit report.

Facility Characteristics

Cottrell House is one of seven medium-restriction halfway houses operated by the TJJD. The campus is located in Dallas, Texas, and serves adolescent males between the ages of 13.3 - 18.11 during an

average length of stay of 74 days. Youth are transitioned to Cottrell from TJJD secure facilities or contracted secure facilities once transition requirements are met. The facility's capacity is 24 and is comprised of one house that contains six bedrooms that can accommodate up to four youth each, a day area, dining area, kitchen, offices, one room where education services are provided, bathrooms, and a backyard. The house does not contain segregation cells.

A video monitoring system with 36 interior and 18 exterior cameras is located throughout the facility. The cameras can be monitored on supervisors' computers and can store recorded video for up to 90 days.

The average daily population from the first, tenth, and 20th day of the month for the 12 months preceding the audit was 19, and the population on the first day of the on-site was 17. The ethnicity breakdown of the 17 youth as of the first day on site was: eight black, seven white, and two Hispanic. The total number of staff members as reported on the PAQ was 21, and the total number of volunteers and contractors was 20.

Services provided on site include anger management, independent living preparation, education through Dallas Independent School District, higher education courses through Navarro College, community employment opportunities, case management, and mental health services. A contractor who was interviewed and observed conducting a group during the on-site audit provides Alcohol and Other Drugs counseling services. Medical services are provided by University of Texas Medical Branch (UTMB) clinic at a TJJD-operated secure facility. If deemed necessary, SANE/SAFE examinations would be conducted at Parkland Hospital in Dallas, Texas.

The TJJD AID conducts administrative investigations, and the OIG conducts criminal investigations. The OIG is an outside entity, with the Chief Inspector General reporting to the TJJD Board, not the TJJD Executive Director. The Incident Reporting Center (IRC) is maintained by the OIG for the purpose of reporting information concerning abuse, neglect, and exploitation. Youth and staff may make reports by calling the IRC, OIO, or by utilizing the facility grievance system.

Summary of Audit Findings

*The summary should include the number of Standards exceeded, number of Standards met, and number of Standards not met, **along with a list of each of the Standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Note to Auditor:** No Standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each Standard.*

The audit findings are based on evidence that is categorized into three groups: documentation, interviews, and observations. To determine compliance, the auditor analyzed evidence in each group, for each provision, and for each standard. The facility policy is assessed according to the PREA Standards and as outlined in the PREA Audit Tool. The auditor assessed supporting documentation,

interview responses, and observations according to the Audit Tool, the Audit Checklist, and interview protocols. A summary including the assessment of each these three elements follows each standard.

The Interim PREA Audit Report findings included 37 standards in compliance, three standards in noncompliance, and one standard that exceeded compliance. Overall, the facility's policies align with the PREA Standards regarding prevention planning, responsive planning, training and education, screening for risk, reporting, response to allegations, investigations, discipline, medical and mental health care, and data collection and review. Corrective actions are addressed by standard and provision below.

Cottrell's prevention efforts include a zero tolerance of sexual abuse and harassment evidenced by policy, documentation, and interviews; the education of youth regarding the policy; requirements of contracted entities to adhere to the same zero tolerance; staffing plans intended to protect youth against sexual abuse; and disallowing or limiting cross-gender viewing. Cottrell's supervisory staff members conduct unannounced rounds on all shifts, which was evidenced during interviews and documentation review. However, the sample reviewed for the previous 10 months indicated that most were conducted on Saturday and least on Tuesday and Wednesday. This trend is detailed below ins.313. A video monitoring system with cameras located throughout the interior and exterior of the buildings augments the zero-tolerance efforts. Interviews with staff and youth indicated they had received training and information regarding the right to be free from sexual abuse and harassment and all could articulate how to make reports. All but one staff member articulated an understanding of cross-gender and/or transgender pat down searches; however, one was unsure about when or if these searches would be warranted. Additional details are included in standard 115.315.

Evidence of responsive planning includes providing youth with SAFE/SANE services, policy and procedures regarding investigations, and the training of investigators to obtain usable physical evidence. No forensic medical examinations have been necessary, but facility protocol stipulates that youth requiring such examinations would be transported to Parkland Hospital in Dallas, Texas. The OIG and TJJD's AID reported that no administrative or criminal investigation of sexual abuse and harassment allegations was reported or investigated. Interviews and training records of investigators, facility staff members, and youth indicate they have received relevant training.

Training and education efforts include the development of training curricula, annual staff training, campus meetings, and dorm meetings addressing PREA-specific topics. Youth PREA education occurs during intake in the Ron Jackson State Juvenile Correctional Center (RJSJCC) Orientation and Assessment (O&A) unit. Interviews with youth indicated PREA education is provided upon their arrival to the unit and continues once they are transferred to their permanent placement. Zero tolerance posters in Spanish and English are displayed throughout the house and PREA-related information is included in the youth handbook. During interviews, staff members said they had received PREA training during new-hire and annual trainings. The volunteer and contractor said they received sufficient training regarding PREA policies.

An intake case manager screens each youth for risk of sexual abuse victimization and abusiveness upon the youth's arrival to the agency's O&A unit during the intake interview. The objective screening instrument is used along with psychological assessments to determine housing and room assignments. Subsequent housing decisions are determined by the agency's safe housing reassessments.

Multiple reporting options are present at Cottrell. However, the number for an outside rape crisis center was not provided to youth. This is discussed in detail below in standard 115.321. Grievance procedures are in place, and youth are provided the tools necessary to complete and submit them. During interviews, staff members and youth could articulate multiple reporting options. Additionally, TJJD's policies align with the PREA Standards regarding reporting, responses, and immediate actions following a report of sexual abuse. Cottrell has a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for specific staff members and the actions each must take. Staff members demonstrated an overall knowledge of first responder duties during interviews.

The TJJD AID conducts in-house administrative investigations and the OIG conducts criminal investigations. One investigator from each division was interviewed and demonstrated compliance with each PREA Standard involving investigations, collection of evidence, notifications, referring for prosecution, and actions taken following an investigation. The administrative investigative reports contained all required information including documentation of youth notifications at the conclusion of the investigation. Additional details of the reports are discussed in the investigation section below.

Final PREA Audit Findings

Number of Standards Exceeded: 1

1. 115.317: Hiring and promotion decisions

Number of Standards Met: 37

1. 115.311: Zero tolerance
2. 115.313: Supervision and Monitoring
3. 115.315: Limits to cross-gender viewing and searches
4. 115.316: Residents with disabilities and residents who are limited English proficient
5. 115.318: Upgrades to facilities and technology
6. 115.322: Policies for referrals of allegations for investigations
7. 115.331: Employee training
8. 115.332: Volunteer and contractor training
9. 115.333: Resident education
10. 115.334: Specialized training: Investigations
11. 115.335: Specialized training: Medical and mental health care
12. 115.341: Obtaining information from residents
13. 115.342: Placement of residents
14. 115.351: Resident reporting

15. 115.352: Exhaustion of administrative remedies
16. 115.354: Third-party reporting
17. 115.361: Staff and agency reporting
18. 115.362: Agency protection duties
19. 115.363: Reporting to other confinement facilities
20. 115.364: Staff first responder duties
21. 115.365: Coordinated response
22. 115.366: Preservation of ability to protect residents from contact with abusers
23. 115.367: Agency protection against retaliation
24. 115.368: Post-allegation protective custody
25. 115.371: Criminal and administrative investigations
26. 115.372: Evidentiary standards for administrative investigations
27. 115.373: Reporting to residents
28. 115.376: Disciplinary sanctions for staff
29. 115.377: Corrective action for contractors and volunteers
30. 115.378: Disciplinary sanctions for residents
31. 115.381: Medical and mental health screenings; history of sexual abuse
32. 115.382: Access to emergency medical and mental health services
33. 115.383: Ongoing medical and mental health care
34. 115.386: Sexual abuse incident review
35. 115.387: Data collection
36. 115.388: Data review for corrective action
37. 115.389: Data storage, publication, and destruction

Number of Standards Not Met: 3

1. 115.312: Contracting with other entities
2. 115.321: Evidence protocol and forensic medical examinations
3. 115.353: Resident access to outside support services

Recommendations: 4

1. 115.313: Supervision and monitoring
2. 115.315: Limits to cross-gender viewing and searches
3. 115.351: Resident reporting
4. 115.367: Agency protection against retaliation

Compliance for the standards with recommendations was based on practice and interview information, but the auditor recommended implementing the changes to improve current practice and/or revising policy to improve alignment with PREA Standards; however, the implementation of these recommendations has no implication on compliance.

Summary of Corrective Actions Requested

115.312: The agency did not provide sufficient evidence that contracted facilities were consistently monitored. Additionally, evidence indicates that one contracted facility does not maintain the required 1:18 ratio.

115.321: The facility's coordinated response indicates that the services of a rape crisis center in Waco, Texas would be offered to youth victims of sexual assault. However, evidence does not suggest that an MOU with this center is in place.

115.353: As requested for standard 115.321, the contact information of the rape crisis center listed in the facility's coordinated response was not made accessible to youth, and during interviews, youth stated they were unaware of outside services.

Summary of Actions Taken

On July 23, 2019, the auditor sent the interim audit report via email to the TJJD Compliance Coordinator, TJJD administrative staff members, facility administrators, and the Chief Ombudsman. On August 2, 2019, the TJJD Compliance Coordinator responded to all recipients in a second email, which contained the notification of the permanent closure of Cottrell House. All youth assigned to the facility were moved to other TJJD-operated facilities. The following week, the auditor notified the PRC, received confirmation regarding the process for finalizing the audit and audit report, and shared this information with the appropriate agency and facility staff members. During a phone call on August 20 and in a follow-up email, the Compliance Coordinator provided a summary of actions taken by the facility in response to unmet standards and/or auditor recommendations noted in the interim report. These are described below within the relevant standards.

Since the facility was permanently closed approximately two weeks after the auditor submitted the interim report, the auditor was unable to conduct post-audit interviews with staff and youth during the corrective action period and did not have sufficient time to determine whether the corrective actions were institutionalized at Cottrell House. Thus, the auditor's initial determinations for the three unmet standards remained unchanged in the final audit report. The auditor provided the final report to relevant agency and facility staff members, uploaded the final report to the PRC post-audit reporting form, and included a brief explanation of this process in the corresponding open-response field attached to the form.

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA Standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA Standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (a), (b), (d)(1-2)
3. INS 71.01
4. Cottrell, TJJD, and Monitoring and Inspections organizational charts
5. Youth Handbook

Interviews:

1. Compliance Coordinator
2. Compliance Manager

Observations:

1. Compliance Coordinator and Compliance Manager performing PREA-related duties

(a): The TJJD GAP along with the Institution Operations Policy (INS) outline TJJD's written policy mandating zero tolerance of and TJJD's response to sexual abuse, sexual harassment, or sexual activity. The policies contain PREA-related definitions, general provisions, prevention planning, responsive planning, training and education, screening for risk, reporting, responses following a report, investigations, disciplinary sanctions, medical and mental health care, incident reviews, and data collection and storage.

(b): The TJJD has a designated agency-wide PREA Compliance Coordinator as well as facility-level PREA Compliance Managers. The TJJD, Monitoring and Inspections Division, and Cottrell Organizational Charts evidence the positions of the Interim PREA Compliance Coordinator and facility Compliance Manager within the agency. The agency Compliance Coordinator reports to the Director of Monitoring and Inspections Division. The Cottrell chart shows that the facility Compliance Manager reports to the facility Superintendent. The agency Compliance Coordinator said she has sufficient time and authority to perform her duties and is able to interact with the facility Compliance Managers on a regular basis. The Cottrell Compliance Manager said also said he was sufficient time to accomplish his PREA-related duties.

(c): The TJJD employs an agency Interim PREA Compliance Coordinator and a PREA Compliance Manager at each facility. The TJJD, Monitoring and Inspections Division, and Cottrell Organizational Charts indicate the positions of the PREA Compliance Coordinator and facility Compliance Manager within the agency. The agency Compliance Coordinator reports to the Director of Monitoring and Inspections Division. The Cottrell chart shows that the facility Compliance Manager reports to the facility Superintendent. The primary responsibility of the Coordinator is to coordinate PREA

compliance efforts at each of the TJJD facilities, which includes six secure facilities and eight halfway houses. The Compliance Manager at the facility is responsible for PREA compliance efforts at his or her respective campus. The Cottrell Compliance Manager coordinates all PREA compliance efforts and said he had sufficient time and authority to perform these duties, which include working with facility leadership to ensure new policies, and practices are implemented and deficiencies corrected.

Summary of Findings:

The auditor reviewed the TJJD's PREA Policy and evaluated the document against the requirements of this Standard and the PREA Audit Tool, which stipulate: the policy must a) be written, b) mandate zero tolerance, and c) mandate the designation of agency-wide Compliance Coordinator and facility-level Compliance Managers. The agency's written PREA Policy contains each of these three requirements, which supported compliance with provision (a). The organizational chart includes the Compliance Manager and Compliance Coordinator positions as required by the facility policy and provisions (b) and (c), which supports compliance with these provisions. During interviews, the Compliance Manager stated he had sufficient time to perform his PREA-related duties outlined in provisions (b) and (c). The Compliance Coordinator stated she has sufficient time and authority to be effective in her role as provisions (b) and (c) require. Both staff members stated they have dedicated offices, and throughout the audit, the facility Compliance Manager was observed interacting with facility employees and performing duties related to the audit, which further supported the auditor's determination of compliance with provisions (b) and (c). Based on the documents reviewed, interview responses, and observations, the auditor determined the facility satisfied each element in the Audit Tool, demonstrated compliance with all provisions, and thus meets the requirements of this standard.

Corrective Action: None

Standard 115.312: Contracting with other entities for the confinement of residents
All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA Standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA Standards? (N/A if the agency does not contract with private agencies or other entities for the

confinement of residents OR the response to 115.312(a)-1 is "NO".) ☐ Yes ☒ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. Contracts the agency has entered into for the confinement and care of youth
4. Contract Provider: PREA Continued Compliance Monitoring forms
5. Contract Residential Site Visit forms

Interviews:

1. TJJD Agency Contractor Administrator

Observations: No observations were required, as Cottrell is not a contracted facility.

(a): The TJJD's policy requires that "all new or renewed contracts for residential placement of TJJD youth, TJJD includes a clause requiring the contractor to adopt and comply with applicable PREA standards." The TJJD website indicates it contracts with nine entities, and nine contracts for the confinement of youth were provided prior to the audit. Three foster care/group home contracts do not require compliance with the PREA but do stipulate that the service provider "will be required to provide PREA education to staff and youth as well as post TJJD zero tolerance posters in common areas of the facility/foster home." The other six contracts indicate that they must comply with all PREA standards. The contracts for the facilities required to comply with the PREA include language stating the contractor will "self-monitor" for compliance as well as acknowledge that "TJJD will conduct announced and unannounced compliance monitoring visits." The contracts also state the contractor is "responsible for paying for a PREA audit every three years."

(b): The TJJD requires all of the contracted facilities to comply with the PREA except the three that are foster care/group home programs. The contracts with the six entities required to comply with

PREA all contain language stating that, “during non-audit periods, monitoring shall be done in the same manner TJJD verifies other contract terms.” The contracts state that the service provider will:

- Allow the TJJD/designee to perform monitoring, performance evaluations, investigations, or audits.

- Provide access for inspection and reproduction of all records related to services rendered under this contract that are necessary to facilitate monitoring, performance evaluations, investigations, or audits.

- Records include, but are not limited to, contracts, notes, real property documents, accounting/financial records, written policies and procedures, correspondence, performance evaluation data and reports, and any other information pertinent to revenues, costs, expenses, and performance of services provided under this contract belonging to either Service Provider, its subsidiaries, parent and/or affiliate(s), including subconsultants, subcontractors, employees, and any and all related parties to this contract. "Related Party" is discussed and defined below.

- Upon request by the TJJD, provide facilities to the TJJD/designee to perform any of the functions listed in this subsection, as well as adequate and appropriate workspace and copier.

The agency supplied Contract Provider: PREA Compliance Monitoring forms for 14 PREA monitoring visits conducted from February 2016 to January 2018, which the Compliance Manager stated were the most recent. This auditor was a member of the audit team that conducted the audit for McLennan Residential Treatment Center (MRTC), a secure facility operated by TJJD, on March 21 – 22, 2019. The lead auditor noted the following in that facility’s interim audit report. Since this auditor concurs, and because the corrective action relates to the agency, the corrective actions requested in the March audit of MRTC are also requested here.
The auditor for MRTC noted:

> According to a July 9, 2013, Frequently Asked Questions answer regarding standard §115.312:
>
> > In years when the contract facility is audited, review of the audit report will meet the monitoring requirements. In other years, monitoring may be done in the same manner the agency verifies compliance with other contract terms, which may vary (e.g. on-site agency staff, inspections, documentation, etc.). Whatever monitoring method used should provide the agency assurances that the contractor is complying with the PREA standards.
>
> The Contract Provider: PREA Compliance Monitoring forms indicate that for at least five of the contracted entities, monitoring was not consistently conducted during non-PREA audit years. Additionally, the agency contracts with an entity named TrueCore, The Oaks. This facility had a final PREA Audit Report Issued July 25, 2018. The auditor indicated that the facility met 41 standards, with zero standards not met. However, the auditor marked the report to indicate that the facility does not maintain staff ratios of a minimum of 1:8 during resident

waking hours and that the facility does not maintain staff ratios of a minimum of 1:16 during resident sleeping hours. Additionally, the auditor wrote in the report that:

The Oaks facility adheres to Texas Administrative Code (TAC) 343.436 staffing for single occupation housing units (SOHU) and the TJJD Institution Statement of Work that stipulates a 1:12 staff to youth ratio during programming hours, a 1:16 youth ratio for state youth, and a 1:24 youth ratio for probation youth for non-programming hours.

The Contract Provider: PREA Compliance Monitoring forms indicate that the last TJJD monitoring visit for TrueCore, The Oaks occurred on January 11, 2018. The agency provided no documentation to indicate that they had conducted monitoring to ensure that TrueCore, The Oaks was meeting the PREA required ratios after the issuance of a PREA Audit Report dated July 25, 2018, indicating noncompliance with standard 115.313.

The current Director for Halfway Houses and Contract Care Facilities started with the agency in January 2019. During her interview, she stated that she has toured most of the contract facilities, but she has not begun monitoring them. She said she has been following up on sexual abuse incident reviews via email and has read the reports sent to her. She indicated that she does not have a plan in place for how she will conduct monitoring of the contract facilities and said that she needs to meet with the agency PREA Coordinator to discuss the requirements.

Summary of Findings:

The auditor reviewed the TJJD contract language and evaluated the language against the requirements of this standard and the PREA Audit Tool, which stipulate: 1) the contract must require compliance with the PREA Standards and 2) the contract must provide for monitoring of the contractor. The contract language for all contracts pursuant to this standard requires compliance with all PREA standard, which supports compliance with provision (a). Documentation was not provided to show that the agency has consistently monitored the contract facilities, which does not support compliance with provision (b). Therefore, TJJD does not meet the requirements of this standard.

Corrective Action:

1. Provide evidence to show that the agency is consistently monitoring contract facilities for PREA compliance during non-PREA audit years.

2. Provide evidence to show that the agency has conducted a monitoring visit to ensure that TrueCore - The Oaks is meeting the required staff-to-youth ratios required by PREA.

Corrective Actions Taken since the Interim Audit Report:

On August 2, 2019, the auditor received notification that Cottrell House was permanently closed. The Compliance Coordinator provided the following information regarding corrective actions taken thus far.

1. The PREA Coordinator for the Texas Juvenile Justice Department (TJJD) will now be responsible for actively monitoring all of the applicable contracted residential care facilities for PREA compliance, annually. This process has already been initiated with the PC [PREA Coordinator] conducting an assessment of the TrueCore - The Oaks facility, located in Brownwood, Texas which was conducted from 5/7- 5/9/2019 as well as conducing a PREA compliance assessment of the Gulf Coast Trades Center out of New Waverly, Texas, as recently as 7/15-7/17/2019. A schedule is in place to ensure the active monitoring continues for these and all other applicable residential care facilities for which the agency has an established contract for services.

2. Through the course of the PREA compliance assessment conducted by TJJD in May/ 2019, TrueCore, The Oaks, was cited for non-compliance with the PREA mandated staff to youth ratios of 1:8 during youth waking hours and 1:16 during sleeping hours. As a result of the assessment, TJJD imposed specific corrective actions upon the facility to comply with the required ratios in order to avoid a breach of its current contract with TJJD. Since that time, TrueCore has implemented a strategic plan to improve recruitment and maintain adequate staffing levels.

Since the facility was permanently closed approximately two weeks after the auditor sent the interim report, the auditor was unable to conduct post-audit interviews with staff and youth and did not have sufficient time to determine whether the corrective actions had been institutionalized at Cottrell House. Thus, the auditor's initial determination of unmet for this standard remains unchanged in the final report.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☐ Yes ☒ No

- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or Standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. GAP 380.9955 (d)
4. Halfway House (HWH) Operations Manual
5. Staffing plans
6. Unannounced rounds visit forms that include the staff member's name, shift, and observation notes

Interviews:

1. Facility Superintendent
2. Compliance Manager

3. Compliance Coordinator
4. Staff responsible for conducting unannounced rounds

Observations:

1. Camera placement
2. Video surveillance system
3. Staffing levels during facility inspection

(a): The TJJD policy requires each facility to develop a written staffing plan that considers staffing levels and patterns, video monitoring, and deviations from the plan. The Superintendent must approve the plan for each dorm with consideration given to each element for provision (a) of this standard. The Superintendent and Compliance Manager stated each item in this provision is considered when updating the facility staffing plan. The Superintendent stated that the development process included meeting with case managers, the Compliance Manager, the Director of Halfway Houses, and the Executive Director who review and sign the plan.

The Superintendent stated that to ensure the facility complied with the plan, unannounced rounds were conducted, observations made, schedules adjusted, and incidents reviewed, which has resulted in camera angels being adjusted and/or additional cameras installed. The current and previous three annual staffing plans include supervisory signatures indicating approval.

Additional Safe Housing Staffing Plans from the previous three years illustrate the facility's annual review of the plans.

(b): TJJD policy states that deviations are only permitted during limited and exigent circumstances and that any deviation and the reason for the deviation must be documented. Since the facility did not deviate from their staffing plan, no documentation of deviations was available.

(c): TJJD policy requires that secure facilities maintain a staff-to-youth ratio of 1:12 during youth waking hours and 1:12 during youth sleeping hours. Since Cottrell is not secure, it is not subject to this requirement; however, the HWH Operations Manual requires the facility to maintain a ratio of 1:8 during waking hours and 1:12 during sleeping hours. Direct-care staff members are defined as juvenile correctional officers and other staff with sole supervision training assigned to the direct supervision of youth. The Superintendent said that the ratio was required, followed at all times, and that the facility has not deviated from the ratio. The auditors observed the required ratio during waking and sleeping hours during the on-site portion of the audit.

(d): Three consecutive-year safe housing plans were reviewed, and each includes staffing plan procedures, provisions, revisions to the campus schedules and current population, procedures regarding room assignments, reassessing for safe housing, PREA supervision requirements, and facility floor plan and camera totals. TJJD policy requires the assessment, determination, and documentation of the consideration of adjustments needed to the staffing plan, staffing patterns, video monitoring, and resources committed to ensure adherence to the staffing plan. The Compliance Coordinator stated she was consulted regarding any assessments of or adjustments to the staffing plan

and that staffing plan assessments occurred at least annually. There was no specific documentation, such as meeting minutes or emails, provided to evidence the annual review process; however, the supplied staffing plans were signed each year by the Superintendent, Director of Halfway Houses, and the Compliance Coordinator. The Coordinator stated that a new staffing plan format was being developed that included additional questions, a section for meeting dates and minutes, and a section to note participants in the development process.

(e): TJJD policy requires managerial staff members to conduct and document unannounced rounds at least once per month on each shift. Policy also prohibits staff members from notifying other staff members that unannounced rounds are occurring. Supervisory staff responsible for conducting unannounced rounds said they are required to do so at varied times, must document them on the Unannounced Visit form, and are discouraged from alerting other staff that unannounced visits are occurring. The auditor reviewed 31 PREA Unannounced Visit forms from the previous 10 months. Each included the staff member's name, shift, and observation notes. The documentation indicated that rounds occurred at least three times per month.

Percentages of rounds occurring on each day of the week are as follows.

Sunday	3%	Thursday	6%
Monday	16%	Friday	22%
Tuesday	3%	Saturday	30%
Wednesday	19%		

Summary of Findings:

The auditor reviewed policy, staffing plans and reviews, and unannounced rounds forms. These documents were assessed against the requirements of this standard and the PREA Audit Tool, which require: a) the development and implementation of a staffing plan that provides adequate staffing levels and the determination of the need for video monitoring; b) compliance with the plan and documentation of deviations; c) maintaining PREA-required staffing ratios; d) at least annual assessments of the staffing plan, staffing patterns, video monitoring systems, and available resources; and e) conducting and documenting unannounced rounds.

The facility staffing plan and development process include all elements of provision (a). The facility's review includes staff members' signatures confirming their presence and documented safety measures taken as a result of the review, thus supporting compliance with provisions (a) and (d). Evidence supporting compliance with provisions (a) and (b) was demonstrated during interviews, as the Compliance Coordinator, Superintendent, and Compliance Manager described the staffing plan review process, communicated knowledge of the items in provision (a), and reported the facility had not deviated from the plan. Compliance with provision (b) was evidenced, as the facility did not deviate from their plan and agency policy. To demonstrate compliance with provision (c), the facility must maintain staff ratios of a minimum of 1:8 during waking hours and 1:16 during sleeping hours except during limited or exigent circumstances, and such circumstances shall be documented. The

PAQ indicated the facility did not deviate from the 1:8 ratio in the past 12 months. The facility demonstrated compliance with provision (e) as completed unannounced rounds documentation evidenced the practice of conducting these rounds. Based on the documents reviewed, interview responses, and observations, the auditor determined the facility satisfies all but one element in the Audit Tool and demonstrates compliance with all but one provision. Since the TJJD policy does not require and the facility did not maintain a staff-to-youth ratio of 1:8 as required by provision (c), the auditor determined the facility does not meet the requirements of this standard, and a corrective action was initiated.

Corrective Action: None

Recommendations:

1. During the 10 months prior to the on-site portion of the audit, of the 31 unannounced rounds conducted, 16 were conducted Monday, one on Tuesday, six on Wednesday, two on Thursday, seven on Friday, nine on Saturday, and one on Sunday as illustrated in the table above. To decrease predictability, conduct additional unannounced rounds on Sunday and Tuesday.

2. Compliance for this standard was supported by the description of the development process provided by the Compliance Coordinator, Compliance Manager, and Superintendent. The auditor recommends clearly recording discussions or exchanges of information regarding the assessment, determination, and documentation of the consideration of adjustments needed to the staffing plan, staffing patterns, video monitoring, and resources committed to ensure adherence to the staffing plan. Records could include meeting minutes, sign-in sheets, emails, or documentation of phone calls regarding the discussions or participation in the development process.

Actions Taken since the Interim Audit Report:

On August 2, 2019, the auditor received notification that Cottrell House was permanently closed. The Compliance Coordinator provided the following information regarding actions taken thus far as a result of the auditor's recommendations.

1. The agency's PREA Coordinator will monitor the unannounced rounds for any identified patterns in order to decrease predictability and enhance efforts for effective supervision and monitoring.

2. The facility will be required to submit all relative documentation including sign-in sheets, email and other relevant correspondence along with the submission of the Staffing Plan for final approval.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☐ Yes ☐ No ☒ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?
  ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. GAP 380.9709 (g)
4. TJJD Professional Development Lesson Plan including a narrative with Key Points
5. Shift and search logs
6. Training curricula
7. Staff training logs

Interviews:

1. Compliance Manager
2. Facility Superintendent
3. Random staff

4. Random youth

Observations:

1. Individual rooms
2. Showers and bathrooms
3. Bathroom routine

(a): TJJD policy and the training curriculum page outline the use of cross-gender pat-down and strip searches by the opposite gender. Both state that two trained staff must be present and the staff members conducting the search must be of the same gender as the youth, except in exigent circumstances. Policy allows body cavity searches only with probable cause that the youth has contraband and with the authorization of the facility administrator and must be conducted off-site by medical personnel.

(b): TJJD policy prohibits cross-gender pat-down searches except in exigent circumstances and defines such circumstance but does not provide specific examples. Policy also requires that staff members honor a youth's preference to be searched by a male or female staff member if the youth identifies as transgender or intersex. During interviews, all youth reported being pat searched by a same-gender staff member, and none reported being searched by a cross-gender staff member. No youth who identified as LGBTI was assigned to the facility during the audit.

Staff members stated that cross-gender pat searches were not allowed absent exigent circumstances. All but one provided examples of circumstances that would warrant a cross-gender search. They also understood that these searches must be documented.

Since no transgender or intersex youth was present at the facility or had been assigned to the facility in the last 12 months, the auditor relied upon responses provided during interviews, during which staff members communicated an overall understanding of searching these youth according to their preference and gender identity.

(c): TJJD policy requires that all room and pat-down searches, including any performed by cross-gender staff, are documented. Routine strip-search logs were provided prior to the audit and included the date, youths' names, items found, and the staff member who conducted the search. No cross-gender pat-down searches were noted.

(d): TJJD policy prohibits cross-gender supervision during shower and restroom routine and when youth change clothes except in exigent circumstances or when such viewing is incidental to routine room checks. Staff members of the opposite gender are required to announce their presence when entering the house, a practice that staff members and youth stated was consistently followed. The auditor team observed this procedure during the on-site audit.

During interviews, staff and youth reported that youth were able to undress, shower, and use the bathroom out of view of all staff members including those of the opposite gender and all other youth. The auditors observed youth entering the bathrooms, which have solid doors and provide privacy.

(e): TJJD policy prohibits searching or examining a transgender or intersex youth for the sole purpose of determining the youth's genital status. Staff members communicated an understanding of the

policy during interviews. During the audit and the 12 months prior to the audit, no youth who identified as LGBTI was assigned to the facility.

(f): TJJD policy requires that room and pat-down searches are conducted in a professional manner, and staff must not make jokes, conversation, or comments while conducting searches. Policy also requires that staff conducting a pat-down search must be of the same gender as the youth being searched, except in exigent circumstances. A training module titled *Search Procedures* includes the procedures for pat searches including cross-gender, transgender, and intersex pat searches. A training sign-in sheet for a professional development session described as "conducting routine strip/pat searches" and "review of policy" included staff members' signatures indicating they received and understood the training.

Summary of Findings:

The auditor reviewed policy and training curricula regarding strip, body cavity, and gross-gender searches and compared these documents against the details of this standard and the PREA Audit Tool, which: a) prohibit cross-gender strip and body cavity searches; b) prohibit cross-gender pat searches except during an exigent circumstance; c) require documentation and justification of cross-gender visual body cavity searches and cross-gender pat searches; d) require policy and procedures that ensure residents' privacy while showering, changing clothes, and performing other bodily functions; requires staff members of the opposite gender to announce their presence; e) prohibit examining a transgender or intersex youth to determine genital status; and f) require training regarding searches.

Evidence of compliance includes policy and training materials that align with provisions (a) – (f). Compliance with provision (b) was demonstrated as staff members' responses during interviews indicated they had received sufficient training. The facility demonstrated compliance with provision (c) as search logs showed only allowable searches were performed. The auditor determined compliance with provision (d) because: 1) the auditor observed opposite-gender staff members following policy by announcing their presence and providing youth privacy during bathroom routine, 2) staff and youth reported this was the expected practice, and 3) bathrooms, showers, and rooms were observed to provide privacy to youth when changing clothes, showering, and performing bodily functions. The auditor determined the facility meets the requirements of all provisions after reviewing policy, making observations, and interviewing staff members and youth, and thus, meets the requirements of this standard.

Corrective Action: None

Recommendation:

1. Since one staff member did not demonstrate an understanding of exigent circumstances that would warrant a cross-gender pat search, provide additional training about this process.

Actions Taken since the Interim Audit Report:

1. All staff at the McFadden Ranch will be retrained regarding these specific training components. Consistent refresher training will be a continued responsibility for the facility's PREA Compliance Manager and will be routinely monitored by the agency's PREA Coordinator for compliance.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (If "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. PREA script in English and Spanish
4. Language Line Solutions pamphlet
5. Youth handbook
6. PREA Orientation Training and Acknowledgement Form
7. MOU with translator service

Interviews:

1. Youth with disability/receive special education services
2. Youth with limited English proficiency
3. TJJD Executive Director
4. Staff members who provide PREA training to youth

Observations:

1. Interactions between staff members and residents

(a): The TJJD has taken steps to ensure youth with disabilities have equal opportunity to participate in and benefit from TJJD's efforts to prevent, detect, and respond to sexual abuse. Effective communication with these youth includes utilizing a language line and providing PREA training, orientation, and written materials in accessible formats.

During interviews, intake staff members said that orientation was conducted on the youth's first day at the house. They described the process as a case manager reading the PREA Orientation Script to youth and the youth, reviewing the PREA packet, orienting the youth to the house and noting where hotline numbers were posted, providing a handout, youth watching the PREA video, reviewing youth rights and house rules, and obtaining the youth's signature indicating the information was received.

According to Word's built-in text leveling tool, the PREA script has a reading level of 13.3, and excerpts from the youth handbook pertaining to PREA have a level of 8.4, a modified insert containing PREA-related information with a reading level of 4.9 is placed in each youth handbook.

Posters throughout the house in English and Spanish provide youth with information about how to report abuse, neglect, or exploitation. All youth including one with limited English proficiency and

four who receive special education services reported understanding the information they received regarding Cottrell's zero tolerance policy and reporting options.

(b): TJJD has taken steps to ensure youth who are limited English proficient have equal opportunity to participate and benefit from TJJD's efforts to prevent, detect, and respond to sexual abuse. The language line would be utilized to translate, and English and Spanish versions of the PREA Orientation Script, PREA posters, and youth handbooks are available. All youth including those who have limited English proficiency and received special education services reported understanding the information they received regarding Cottrell's zero tolerance policy and reporting options.

(c): TJJD policy prohibits the use of youth to interpret, read, or otherwise assist except in limited circumstances. Cottrell reported no occurrences of the use of youth interpreters in the last 12 months. Staff members stated they would not use youth interpreters except in exigent circumstances.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require: a) youth with disabilities have equal opportunity to participate or benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and harassment; b) youth who are limited English proficient have meaningful access to these efforts; and c) resident interpreters will not be used except in limited circumstances.

The auditor determined TJJD policy addresses each of these requirements, which support compliance with provisions (a) and (c). Evidence supporting compliance with provisions (a) and (b) include a language line pamphlet with account number that would provide language assistance to youth with limited English proficiency and an MOU with a translator service that would translate for youth who are deaf or hard of hearing. Interviews with staff members provided evidence and of compliance with provisions (a) and (c), as they described the processes for providing PREA-related information to youth and reported that youth interpreters would not be used to assist youth in making a report of sexual abuse or harassment. Although the PREA-related material provided to youth at grade levels ranging from 4.9 – 8.4, the auditor made a final determination of compliance with provision (a) based on youths' understanding and ability to articulate the education they received. Youth signatures acknowledging their receipt of PREA education provided additional evidence of compliance with provision (a). Youth interviews also supported evidence of compliance with provision (c) as they reported youth readers were not used to relay information or to assist in making reports. When considering whether staff members effectively communicated with youth, the auditor observed staff members interacting with youth and determined that general communication with youth was age appropriate.

Corrective Action: None

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. PRS 02.07
4. GAP 385.8181(d)
5. PRS 02.08 (f)(1)(A)(ii)
6. Personnel files
7. Snapshot provided by the TJJD Human Resources Administrator showing hire date, initial and annual criminal background checks, and fingerprint dates

Interviews:

1. Human Resources Operations Manager
2. Agency central office human resources administrative staff

Observations: No observations relative to this standard were required

(a): TJJD policy prohibits hiring or promoting anyone who may have contact with youth and using the services of any contractor who may have contact with youth if the person 1) has engaged in sexual abuse in a prison, lockup, community confinement facility, juvenile facility, or other institution or 2) has been convicted or civilly or administratively adjudicated of engaging or

attempting to engage in such activities. The personnel files of two recently hired staff members were reviewed on site, and the hire dates and background checks of one recently promoted employee, four facility employees, two volunteers, and one contracted counselor were reviewed prior to the audit. Each contained criminal background checks, disclosure of PREA Standards violations, reference checks, Child Abuse Registry checks, and acknowledgment forms from PREA annual and refresher trainings.

(b): TJJD policy requires that for any person who may have contact with youth, TJJD consider any incidents of sexual harassment in determining whether to hire, promote, or contract for services. The Human Resources Operations Manager said that all new employees, volunteers, and contractors were vetted prior to being hired the sex offender registry; fingerprints were submitted, and the agency is notified of any new arrests; and background checks were conducted annually.

(c): TJJD policy requires that before hiring a new employee who may have contact with youth, TJJD conducts 1) a criminal background check, 2) child abuse registry check, and 3) contact of prior institutional employers to determine any substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Forms placed in each personnel file include Background Reference Check, Internal Background Review, Disclosure of PREA Employment Standards Violation, and Child Abuse Registry Check Consent Form. The facility reports that in the past 12 months, criminal background checks were conducted for four persons hired and two contractors who may have contact with youth. Interviews with Human Resources Operations Manager verified the practice of conducting such checks for all employees.

(d): TJJD policy requires that before enlisting the services of a contractor who may have contact with youth, TJJD performs criminal background checks and consults the Child Abuse Registry. The facility reports that in the past 12 months, criminal background checks were conducted for two contracts for services. The background check of one contractor was reviewed and indicated a criminal background check was conducted prior to the contractor having contact with youth.

(e): TJJD conducts annual criminal background checks, which exceeds the requirement of conducting checks at least every five years. The Human Resources Operations Manager stated annual checks are conducted for staff, volunteers, and contractors. The initial and annual criminal background check histories of Cottrell employees and additional personnel file review also support compliance with this standard.

(f): TJJD policy requires that applicants and employees who may have contact with youth have an affirmative duty to disclose misconduct described in Subsection (a). The Disclosure of PREA Employment Standards Violation form placed in all personnel files supports compliance with this provision. The agency Human Resources Operations Manager stated staff must disclose any misconduct.

(g): TJJD policy requires that material omissions regarding such misconduct or the provision of materially false information is grounds for termination.

(h): TJJD policy requires that unless prohibited by law, TJJD provides information on substantiated allegations of sexual abuse or harassment involving a former employee upon receiving a request from an institutional employer for whom the former employee has applied to work. Interviews with Human Resources Operations Manager support compliance with this practice.

Summary of Findings:

The auditor assessed TJJD policy and the employment application process against the elements of this standard and the PREA Audit Tool, which require: a) the agency shall not hire or promote anyone who has engaged, been convicted of, or has been adjudicated to have engaged in sexual misconduct; and b) the agency consider incidents of sexual harassment when hiring or promoting employees or contracting services.

Based on the comparison, the auditor determined that TJJD policy aligns with the requirements of provisions (a) – (f). The auditor reviewed personnel files and materials provided by the TJJD Human Resources Department and determined necessary background and criminal history checks were conducted more frequently than provision (e) requires. Additional evidence relied upon for provision (f) included verifying that all employee files contained an annual Disclosure of PREA Employment Standards Violation that was attached to the employee's annual performance evaluation. During interviews, Human Resources Operations Manager articulated the agency's and facility's hiring and promotion processes as described in policy and this standard. Two files of employees who had recently been promoted indicated that a background check was conducted prior to the promotion. The auditor determined TJJD and Cottrell exceed the requirements of this standard based on the interview responses, documentation review, and evidence of annual background checks.

Corrective Action: None

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.) ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Facility map with buildings and camera numbers

Interviews:

1. Superintendent
2. Executive Director

Observations:

1. Camera placement

(a): This subsection is not applicable, as the facility has not made substantial expansions or modifications. The Executive Director stated that TJJD continually strives to protect youth, preserve youths' modesty and privacy, and ensure blind spots are remedied.

(b): Since the last PREA Audit, no additional video cameras were installed. However, the Superintendent and Executive Director reported that the safety, including sexual safety, of youth is

considered when installing the cameras. The Executive Director also stated that the recently implemented use of body-worn cameras in TJJD's secure facilities has assisted in validating and preventing complaints.

Summary of Findings:

Because the agency did not acquire a new facility and Cottrell had not made substantial expansions or modifications, the auditor determined compliance with provision (a). When considering compliance with provision (b), the auditor: 1) reviewed the facility staffing plan, 2) noted camera placement during the facility inspection, and 3) reviewed the responses of the Superintendent and Executive Director. The staffing plan references the video monitoring system indicating this topic was considered. The interview responses confirmed that when cameras are added, the intent is to provide additional safety. The cameras and live feed observed during the on-site audit confirmed the camera placement provided additional coverage. For these reasons, the auditor determined compliance with provision (b), and thus the facility meets the requirements of this standard.

Corrective Action: None

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☐ Yes ☒ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (f)
3. HWH 17.01 (c)
4. MOU between Cottrell House and the Advocacy Center for Crime Victims & Children in Waco, Texas
5. Website for Parkland Hospital in Dallas, Texas
6. Cottrell House Written Plan for Coordinated Response

Interviews:

1. Staff members
2. Compliance Manager
3. Compliance Coordinator
4. Executive Director of the Advocacy Center for Crime Victims & Children

5. Random youth

Observations: No observations relative to this standard were required.

(a): The OIG is responsible for conducting all criminal investigations. The TJJD AID conducts all other sexual abuse and harassment allegations involving staff members. The OIG investigators generally work Monday through Friday but are on call during non-work hours. When sexual abuse allegations are made, the facility procedures are outlined in policy and the Cottrell House Written Plan for Coordinated Response to Allegations of Sexual Abuse. During interviews, staff members described their understanding of the evidence collection process. All articulated their first responder duties and stated they would separate the youth, protect the scene, and notify supervisory staff and the IRC. All understood that OIG and AID were responsible for conducting investigations.

(b): TJJD policy requires that the agency follow a uniform evidence protocol when responding to allegations sexual abuse and states that the protocol must be developmentally appropriate for youth. Both agency (AID) and outside (OIG) investigators follow a uniform evidence protocol, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition, April 2013.*

(c): TJJD policy requires that when appropriate, TJJD transports youth who experience sexual abuse to a hospital that can provide a medical examination by a SANE or SAFE. If such exams were necessary, depending on the age of the youth, Cottrell would transport youth to Parkland Hospital in Dallas, Texas. The auditor viewed the websites of the hospital to verify these services were available. The PAQ indicated no SAFE/SANE exams have been necessary since the last PREA audit.

(d): The auditor reviewed the MOU between Cottrell and Advocacy Center for Crime Victims & Children in Waco, Texas. The MOU contains the signature lines for a previous TJJD Executive Director, TJJD Attorney, and Hotline Organization. No dates are included in the details of the MOU, and none accompany the signature line.

The auditor team interviewed the Executive Director of the crisis center who reviewed all current MOUs with the center's administrative staff member. The Director described the services that would be provided; however, she stated that she could not locate and was unaware of an MOU with Cottrell and would likely be unable to provide advocacy services to residents in Dallas, Texas where Cottrell is located, because the distance would be a barrier.

The Compliance Manager stated that as of the day of the on-site audit, youth would be taken to Parkland Hospital for forensic examinations. He said the facility was working to enter into an MOU with a different hospital that would provide this service as well as outside victim advocacy services. The Compliance Coordinator stated that since Cottrell was seeking to enter into a new MOU with a different entity, youth were not provided information regarding outside victim advocacy services to prevent confusing them.

No youth who had reported a sexual abuse was assigned to the facility; therefore, this interview was not conducted.

(e): Although the coordinated response plan states that the crisis center in Waco, Texas would be notified if the youth requested advocacy, the Compliance Manager stated during his interview that a 24-hour on-call mental health professional housed at one of two TJJD secure facilities would be notified to assist the youth. However, the name and number of the on-call mental health professional provided prior to the on-site audit was located at another TJJD halfway house.

No youth who had reported a sexual abuse was assigned to the facility; therefore, this interview was not conducted.

(f): As indicated above in provisions (a) – (e), TJJD policy addresses each requirement of this standard. Although the OIG is considered an outside investigating entity, TJJD policy outlines the responsibilities of the OIG.

(g): The auditor is not required to audit this provision.

(h): The auditor reviewed the personnel records of Cottrell staff members to ensure background checks were conducted per policy and to confirm they received the annual and refresher PREA-related training that is required of all Cottrell staff members. No documentation regarding their training in forensic examination issues was provided.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require: a) following a uniform evidence protocol for obtaining usable physical evidence; b) using a developmentally appropriate protocol based on *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*; c) offering forensic medical examinations at no cost to the resident; d) attempting to make outside victim services available; e) providing a qualified victim advocate to accompany residents through the examination process; f) requesting the investigating agency follow the requirements of this standard; and g) ensuring the staff member who serves in this role is screened and receives education regarding sexual assault and forensic examinations. The auditor determined TJJD policy contains the requirements of all provisions of this standard except (d) and (e).

Staff members' overall knowledge regarding the collection of evidence and actions to be taken following an allegation of sexual abuse supported compliance with provisions (a) and (b). Additional evidence supporting compliance with these provisions includes the facility's use of the National Institute of Corrections: *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* for investigator training and certificates of completion of this training.

The facility coordinated response indicates youth would be taken to Parkland Hospital in Dallas, Texas. The hospital's website indicates these services are provided, which demonstrated compliance with provision (c). During interviews, youth were unaware of outside services; therefore, they would not be able to request the services as policy dictates. According to GAP 38.9337, these services are

offered and youth are made aware of phone numbers and addresses of the services, which demonstrated compliance with provision (d). However, the coordinated response states that Advocacy Center for Crime Victims & Children would provide outside services to Cottrell youth, but the Director of the center stated no MOU was in place and distance would be a barrier, which does not indicate compliance with provision (d).

The auditor determined compliance with provision (f), as the OIG, the entity that conducts criminal investigation, is required to adhere to provisions (a) – (e) as outlined in TJJD GAP. Training records for Cottrell staff members indicate all received the required PREA-related training, which partially supports compliance with provision (h). Compliance with provision (e) could not be determined, as it is unclear who would accompany the youth to the forensic examination and provide the supports pursuant to this provision. Since the person who would provide these services to youth was unclear, training records to support compliance with provision (h) were not reviewed.

Since the auditor determined Cottrell did not demonstrate compliance with provisions (c), (d), (e), and (h), the facility did not meet the requirements of this standard, and a corrective action was initiated.

Corrective Action:

1. Provide an updated MOU with a rape crisis center that will provide advocacy services to youth victims. If an MOU is not achieved, 1) provide documentation of the facility's efforts to enter into an MOU, and 2) provide the names of TJJD mental health professionals that would serve as victim advocates.

2. Update the coordinated response plan to include the procedures Cottrell staff members would follow to offer and ensure victim advocacy services that would be provided to victims.

3. Provide training to staff members regarding the changes to the coordinated response plan so that they are aware that the services of a crisis center should be offered to the victim prior to the SAFE/SANE.

Corrective Actions Taken since the Interim Audit Report:

On August 2, 2019, the auditor received notification that Cottrell House was permanently closed. The Compliance Coordinator provided the following information regarding corrective actions taken thus far.

1. All youth formerly assigned to the Cottrell House have been reassigned to the McFadden Ranch [a medium-restriction facility operated by TJJD]. The McFadden Ranch already operates in accordance with an executed MOU with the Abigail's Arms Cooke County Family Crisis Center.

2. The Coordinated Response Plan for McFadden Ranch was already updated to include the information about advocacy services provided through Abigail's Arms Cooke County Family Crisis Center as of March 26, 2019.

3. The Administrative leadership for McFadden Ranch will ensure that all staff are trained or retrained on the updated Coordinated Response Plan.

Since the facility was permanently closed approximately two weeks after the auditor sent the interim report, the auditor was unable to conduct post-audit interviews with staff and youth and did not have sufficient time to determine whether the corrective actions had been institutionalized at Cottrell House. Thus, the auditor's initial determination of unmet for this standard remains unchanged in the final report.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQs
2. GAP 380.9337 (f), (k)
3. GAP 380.9333(a) and (b)
4. Incident reported to the OIG's Incident Reporting Center

Interviews:

1. TJJD Executive Director
2. OIG Investigator
3. AID Investigator
4. TJJD website: http://www.tjjd.texas.gov/
5. Human Resources Code Chapter 242: https://statutes.capitol.texas.gov/Docs/HR/htm/HR.242.htm

Observations: No observations relative to this standard were required.

(a): The OIG is responsible for conducting criminal investigations for TJJD, and AID is responsible for conducting administrative investigations. Although TJJD policy outlines the responsibility of the OIG, and OIG and TJJD share administrative functions, the Chief Inspector General reports to the

TJJD Board, not to TJJD's Executive Director. TJJD policy requires that the OIG review all allegations of sexual abuse and harassment and assign each allegation to the appropriate TJJD department to complete a criminal or administrative investigation. Policy also states that OIG investigations must be documented in a written report that includes descriptions of evidence, credibility assessments, and findings. A uniform evidence protocol, *National Protocol for Sexual Assault Medical Forensic Examinations,* Second Edition, April 2013, is used to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

TJJD policy also outlines the responsibility of the AID when conducting investigations of sexual abuse to include an effort to determine whether staff actions contributed to the abuse and documentation in a written report that includes descriptions of evidence, credibility assessments, and findings.

The Executive Director said that all allegations are routed through the OIG, and investigations must be completed for all allegations of sexual abuse or harassment.

The facility, OIG, and AID reported that no PREA-related investigations had been conducted at Cottrell in the past 12 months; therefore, investigative reports were not reviewed.

(b): TJJD policy requires that all allegations of sexual abuse or harassment are reported to the TJJD OIG, which reviews, assigns, and documents each allegation. Policy, which is posted on the TJJD website, governs administrative investigations and stipulates that the policy does not apply to criminal investigations conducted by the OIG. Additional details of the OIG's authority are described in provision (a) and in the Pre-Audit section above. During interviews, investigative staff supported compliant investigative practices. The auditor reviewed one report that was reported to the OIG IRC, which provided evidence that complaints are routed through the OIG.

(c): The auditors reviewed the TJJD website, which describes the agency AID and OIG duties. The website describes the OIG as being created by the Texas Legislature to "investigate crimes committed by the departmental employees, and crimes and delinquent conduct committed at departmental facilities." All relevant administrative rules are published on the agency's website, including GAP 380.9333(a) and (b) which states that the agency conducts administrative investigations involving abuse, neglect, or exploitation allegedly committed by employees, volunteers, or other individuals working in TJJD programs or facilities. The policy also states that unless specifically noted, this rule does not apply to criminal investigations conducted by the OIG.

(d): The auditor is not required to audit this provision.

(e): The auditor is not required to audit this provision.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency ensures that an investigation is completed for all allegations, b) the agency ensures allegations are appropriately referred for investigation and this information is public,

and c) if a separate entity conducts criminal investigations, the publication describes those responsibilities.

The auditor determined the policy includes each element, which supports compliance with provisions (a) – (c). The TJJD Executive Director demonstrated knowledge of the investigation process during her interview, which provided additional evidence of compliance with provision (a). The OIG and AID investigators demonstrated their knowledge of investigation procedures during interviews, which supported compliance with provisions (a) and (b). A determination of compliance with provisions (b) and (c) was made following the auditor's review of TJJD policy to confirm investigative responsibilities were appropriately described and by visiting the TJJD website to confirm the agency publishes the policy. The facility demonstrated compliance with all provisions and thus meets the requirements of this standard.

Corrective Action: None

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)
3. PREA and Preventing Sexual Misconduct staff development lesson plan with course description, performance objectives, and materials
4. PREA and Preventing Sexual Misconduct training sign-in sheets
5. LGBT definitions handout
6. Trauma in LGBT Youth PowerPoint
7. Juvenile Justice Training Academy Lesson Plans titled:
    a. Gender and Sexuality: A Changing Perspective
    b. Prison Rape Elimination Act (PREA)
    c. Search Procedures

Interviews:

1. Medical and mental health care staff members
2. Random staff members

Observations:

1. Interactions between staff members and youth

(a): TJJD policy requires that all staff members who may have contact with youth attend training that addresses each of the 11 elements in this subsection. During interviews, medical and mental health care staff and random staff members reported they had been trained on each element during new-hire and annual refresher training and received PREA-specific trainings during facility meetings, which training sign-in sheets confirmed. Multiple lesson plans and training materials were uploaded and address each item and provide an overview of the PREA as well as TJJD policy and practices related to sexual abuse. The following items were provided:

- Cross-gender Pat Search and Transgender Pat Search
    - Training script regarding these searches
    - Sign-in forms

- Gender and Sexuality: A Changing Perspective - discusses sexual orientation, gender identity, and gender expression related to issues in the juvenile justice system
    - Strategies and communication to create a supportive and inclusive environment

- New-hire training - PREA and Preventing Sexual Misconduct
    - Sign-in forms
    - Lesson Plan

- LGBT Definitions Handout – provides information and definitions specific to this population

- Meeting the Needs of Gender-Diverse Youth PowerPoint - discusses vocabulary such as gender expression and transgender, pronouns, accommodations, treatment-related problems, and gender inclusiveness

(b): The training materials are tailored to the unique needs of juveniles and although the training materials are not gender-specific, they are appropriate for males and females. Additionally, the facility only houses males. TJJD policy requires additional training if an employee is reassigned from a facility that houses only male youth to a facility that houses only female youth. The Prison Rape Elimination Act (PREA)-ecourse and PREA and Preventing Sexual Misconduct classroom course each contain information that is tailored to working with the adolescent male population of Cottrell. These courses discuss adolescent development and youth behaviors and reactions.

No staff members had transferred to Cottrell from a female facility and none of the interviewed staff reported transferring from a female facility; therefore, there were no training records to review.

(c): The facility reports that 350 employees are currently employed by the facility who may have contact with youth, all of whom were trained or retrained on the PREA requirements outlined in provision (a).

(d): TJJD policy requires that training and the employees' receipt and understanding of PREA training is documented on the agency sign-in and acknowledgement form. Sign-in and acknowledgement of understanding forms were provided for the annual PREA and Preventing Sexual Misconduct.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) employees receive training on 11 specific topics; b) the training is unique to the characteristics of the facility and additional training is provided when a staff member transfers from a

male to female living unit, or vice versa; c) training remains current and refresher training occurs every two years; and d) training is documented.

The auditor determined TJJD policy contains each of the 11 elements pursuant to provision (a), which supports compliance with provisions (a) – (c). The auditor interviewed random and medical and mental health care staff and concluded they received, understood, and communicated sufficient knowledge about the 11 items during annual and refresher training. The auditor observed female staff members following PREA guidelines when entering the house, as they announced their presence when entering. The auditor also observed staff members communicating professionally with youth. The auditor reviewed the training curricula and determined the topics are applicable to the characteristics of Cottrell in that the training is juvenile-specific, which supports compliance with provision (b). The auditor reviewed training records and signature sheets to confirm employees received and acknowledged they understood the training, which meets the requirement of provision (c). Since the facility demonstrated compliance with each provision, the auditor determined Cottrell meets the requirements of this Standard.

Corrective Action: None

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)
3. Training sign-in sheets
4. Volunteer orientation training outline
5. Volunteer Training Manual

Interviews:

1. Volunteer who has contact with youth
2. Contractor who has contact with youth

Observations: No observations relative to this Standard were required.

(a): TJJD policy requires that all volunteers and contractors who have direct access to youth are trained on and understand their PREA-related responsibilities and procedures. The facility reported that 20 volunteers and contractors who have such access have been trained. During interviews, one volunteer and one contractor reported receiving training on their responsibilities regarding sexual abuse prevention, detection, and response. They said they were trained on the facility's zero tolerance policy, how to make a report, what should be reported, and to whom to report. They said the training was provided when they first gained access to the campus and have received periodic refresher training during house meetings and following PREA-related incidents. Both stated they understood TJJD's zero-tolerance policy, and both said they understood their reporting requirements. The sign-in and acknowledgement of understanding forms indicate volunteers and contractors received PREA orientation training.

The volunteer training manual covers multiple topics including the agency's zero-tolerance policy, applicable reporting laws and policies and common myths related to sexual misconduct. The agency provided a TJJD volunteer PowerPoint presentation that contains a slide that discusses PREA and the agency's zero tolerance policy and states that all incidents must be reported and provides the IRC hotline number.

(b): The facility reported that the level and type of training the volunteers and contractors receive is based on the services they provide and level of contact with youth. The sign-in and acknowledgement of understanding forms indicate volunteers and contractors received a PREA orientation training.
(c): Volunteer and contractor sign-in and acknowledgement of understanding forms indicate they received and understood the PREA training.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) volunteers and contractors who have contact with residents receive training, b) the level of training is based on the service provided and level of contact, and c) the training is documented. The auditor determined that TJJD policy addresses all of the required elements, which support compliance with provisions (a) – (c). The auditor interviewed one volunteer and one contractor to confirm they received and understood the PREA-related training, to demonstrate compliance with provision (b). The auditor reviewed the training signature sheets to confirm training was documented and maintained, which supports compliance with provision (c). Based on the interview responses and documentation review, the auditor determined sufficient evidence was present for each provision, and thus the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)
3. Intake records including youth education
4. PREA Orientation and Acknowledgement Form
5. Youth handbook
6. Hotline posters in common areas

Interviews:

1. Intake staff
2. Random youth

Observations:

1. Posters containing PREA-related information

(a): All youth committed to the TJJD begin their stay at the RJSJCC O&A unit. Agency policy requires that youth receive comprehensive, age-appropriate information about TJJD's zero-tolerance policy and how to report incidents of sexual abuse or harassment. Each time a youth transfers to a different TJJD facility, he or she receives the same information. The facility reported that all 88 youth received the comprehensive PREA education upon their arrival to Cottrell.

The auditor reviewed 16 electronic records prior to the audit and three youth master files on site. Each included signed and dated PREA Orientation Training and Acknowledgment forms, Youth Orientation Checklist, intake screening forms, safe housing assessments and reassessments, and psychological evaluations. Also present were dated staff witness signatures confirming youth participation in PREA education during the process.

Zero tolerance posters in Spanish and English were displayed throughout the campus. Intake staff members said that they provided youth with PREA-related information and how to report incidents of sexual abuse or harassment. They described the process as including reading the PREA script, requiring youth to view the PREA video, explaining the locations of zero-tolerance posters. They also stated they complete a safe house reassessment upon the youth's admission to Cottrell.

All youth reported receiving information about their right to be free from sexual abuse or harassment, reporting options, and the right not to be punished for reporting on the first day they arrived to Cottrell.

(b): TJJD policy requires that within 10 calendar days of admission to the O&A Unit, TJJD provides comprehensive, age-appropriate education to youth about 1) their right to be free from sexual abuse or harassment and retaliation for reporting such incidents and 2) TJJD policy and procedures for responding to such incidents. During interviews, intake staff members stated that on the first day of arrival, they read the English or Spanish version of the PREA Orientation Script to youth and show the PREA video, *Safeguarding Youth Sexual Safety PREA Orientation.* When youth are transferred from one TJJD facility to another, they are to receive the education again. Youth corroborated this practice during interviews and said they received the education and watched the PREA video during intake, periodically throughout their stay, when they transferred to Cottrell, and periodically during their stay at the halfway house.

(c): TJJD policy requires that TJJD provide the PREA education each time a youth transfers to a different TJJD-operated facility. Staff and youth interviews supported compliance with this practice.

(d): TJJD policy requires that the agency provide PREA information in formats accessible to all youth including those who are limited English proficient, deaf, visually impaired, otherwise disabled, or have limited reading skills. The Superintendent and Compliance Coordinator said that if a youth spoke a language other than English or Spanish, staff would contact Language Line for translation services to ensure the resident understood the PREA materials. The PREA script and youth handbook contain PREA-related information accessible to all youth.

(e): TJJD documents youth participation in PREA education by requiring youth to acknowledge their understanding by signing and dating the PREA Orientation Acknowledgment Form. The intake records included the Youth Orientation Checklist, PREA Orientation Training and Acknowledgment Form, and receipt of youth handbook form. Also present were dated youth and staff witness signatures showing youth participation in PREA education during the intake process. During

interviews, staff and youth said they participated in PREA-related training and groups upon their transfer to Cottrell and periodically during their stay.

(f): PREA information is available and visible to youth through posters and youth handbooks in English and Spanish. The auditor team noted the posters were visible common areas during the facility inspection. Youth said they received PREA-related information during intake and continuously throughout their stay.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) during intake, residents receive PREA-related information in an age-appropriate manner; b) within 10 days, residents receive comprehensive age-appropriate PREA education; c) current residents who have not received PREA-education, shall be educated within one year; d) education is provided in accessible formats; e) resident education is documented; and f) key information is available and visible.

The auditor determined policy addresses each provision. A review of intake records, youth signature sheets, and the youth handbook, demonstrated that the facility is compliant with provision (a) because the information is comprehensive. The auditor used the leveling tool described in standard 115.316 to measure the age-appropriateness and readability of the written material contained in the orientation packet and determined the material to be written at a level that is not accessible to all youth. However, an insert is placed in the handbooks of youth with low reading skills and youth or who have a disability. Youth with these designations reported receiving and understanding the PREA education they received, which provided the auditor with sufficient evidence of compliance with provision (a). The auditor determined compliance with provision (b) based on the facility's practice of exceeding the requirement to provide comprehensive education within 10 days of intake. The auditor verified this practice by asking questions during youth and the intake staff member interviews and by checking the date of intake against the date of youth signatures acknowledging the education was provided. The auditor determined compliance with provision (c), as the facility reported that all youth had received the education. Additionally, all youth interviewed reported receiving the education, and all files reviewed contained documentation of the education. The same method for standard 115.316 and provision (a) of this standard was used to determine compliance with provision (d); the auditor concluded that the insert mentioned in provision (a) provided sufficient evidence that written PREA information is in a format that is accessible to youth with disabilities and/or low reading skills. The youth signature sheets provided evidence for the auditor to determine compliance with provision (e). During the facility inspection, the auditor noted the placement of posters containing PREA-related information that were visible in common areas. Since the facility demonstrated compliance with all provisions, the auditor determined that Cottrell meets the requirements of this standard.

Corrective Action: None

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)
3. Certificates of Completion of National Institute of Corrections (NIC) Training
4. TJJD AID training agenda and lesson plan

Interviews:

1. OIG Investigator
2. AID Investigator

Observations: No observations relative to this standard were required.

(a): In addition to the general PREA training, TJJD policy requires that TJJD staff members who investigate allegations of sexual abuse receive specialized training that includes interviewing juvenile sexual abuse victims. The auditor verified the AID and OIG investigators who were interviewed received certificates of completion of *PREA: Investigating Sexual Abuse in a Confinement Setting* by the NIC. The two investigators interviewed stated they received this training, which included interviewing techniques, evidence collection, and use of Miranda and Garrity warnings.

(b): TJJD policy requires investigator training to include the elements of this standard. The facility provided the following for review:

- Lesson plan and PowerPoint for course titled Conducting Quality Investigations
- Interview and Interrogation PowerPoint
- The OIG Standard Operating Procedures
- Sexual Abuse Investigations lesson plan and PowerPoint

- Certificates of completion of the *PREA: Investigating Sexual Abuse in Confinement Setting* by the NIC for all investigators assigned to Cottrell

The two investigators interviewed said they received the training above, which including Miranda and Garrity warnings. The AID investigator said he would use the Garrity warning for any staff members under administrative investigation, and the OIG investigator stated OIG would use Miranda when a staff member is the suspect.

(C): The auditor verified certificates of completion of the required training for the AID and OIG facility investigators.

(d): This subsection does not apply; the agency is responsible for conducting administrative investigations. The OIG conducts criminal investigations.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) facility investigators receive additional training in conducting investigations, b) the training contains specific elements, and c) the completion of the training is documented.

The auditor concluded each element of this standard is sufficiently referenced in policy, which supports compliance with provisions (a) – (c). The auditor reviewed certificates of completion of the NIC investigation training and local training materials, which provide additional evidence of compliance with provisions (a) – (c). Further compliance was demonstrated during interviews of the AID and OIG investigators as they provided details about and communicated understanding of the training they received. Compliance with provision (c) was determined based on the certificates of completion provided to the auditor. Since the facility demonstrated compliance with all provisions, the auditor concluded Cottrell meets the requirements of the standard.

Corrective Action: None

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this Standard either from the agency or elsewhere? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §1? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337(g)
3. Certificates of completion of PREA training
4. Training records in personnel files

Interviews:

1. Medical and mental health care staff

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that full- and part-time medical and mental health staff are trained in how to detect and assess signs of sexual abuse, preserve physical evidence, respond to victims of sexual abuse, and report allegations or suspicions of sexual abuse. Certificates of completion of the online course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* by NIC were reviewed for the mental and medical health practitioners assigned to Gainesville State School, a TJJD secure facility where youth receive their routine medical services. An Annual PREA Training Acknowledgment Form and Sign-in Sheet included signatures indicating attendance and understanding of the training. The primary mental health professional is located in another TJJD-operated halfway house, and secondary is the Gainesville on-call psychologist.

(b): This subsection is not applicable; TJJD policy requires that an off-site SANE/SAFE nurse conduct forensic medical exams.

(c): The auditor reviewed documentation to verify that medical and mental health care staff received appropriate PREA training. In addition to the NIC online training, all staff members attend annual training, which includes PREA-specific topics.

(d): TJJD policy requires that full- and part-time medical and mental health staff are trained in each of the 11 required elements outlined in Standard 115.331 (a). Lesson plans address each item and provide an overview of the PREA as well as TJJD policy and practices related to sexual abuse. Certificates of Completion of the online course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* by NIC were reviewed for mental and medical health care staff members. During interviews, medical and mental health care staff reported they had been trained on each element during new hire and annual refresher training and received PREA-specific trainings at the facility.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) medical and mental health care staff members receive PREA-related training, b) medical staff who conduct forensic examinations receive PREA-related training, c) the training is documented, d) medical and mental health care staff members receive training pursuant to standard 115.331 and/or 115.332. The auditor determined each element of this standard is addressed in policy, which supports compliance with provisions (a) – (d). The signature sheets acknowledging the receipt and understanding of the training received by medical and mental health care staff members as well as the responses given during interviews led the auditor to a determination of compliance with provision (a). Provision (b) was not applicable, as the auditor confirmed forensic examinations are conducted off site. The auditor determined compliance with provision (c) because the signature sheets provided prior to the onsite audit and those observed in personnel files confirmed medical and mental health care staff received and understood the training. Additional signature sheets confirmed that all staff members, including medical and mental health care staff received training pursuant to Standards 115.331 and 115.332. Since the auditor concluded the facility is compliant with each provision, Cottrell meets the requirements of this standard.

Corrective Action: None

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained: During classification assessments? ☒ Yes ☐ No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this Standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (h)
3. Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization form
4. Safe Housing Assessment/Reassessments in the Correctional Care System (TJJD online database)

Interviews:

1. Random youth
2. Staff responsible for risk screening
3. Compliance Manager
4. Compliance Coordinator

Observations:

1. The area where youth files are stored was described to the auditor following the audit, as the auditor did not view this area during the audit.

(a): TJJD policy requires that within 72 hours of intake and periodically throughout their confinement, an objective assessment is used to obtained information about each youth's history and behavior to reduce the risk of sexual abuse by or upon another youth. Policy also requires that information from the screening instrument is used periodically throughout the youth's stay to reassess housing and supervision assignments. A safe housing reassessment is also completed upon facility transfer, at least once every 90 days, automatically within one day of a major rule violation proven true in a hearing, turning age 17, or following a serious suicide attempt. The facility reported on the PAQ that 88 youth entered the facility in the past 12 months and that all were screened for risk of sexual victimization or perpetration. Safe housing assessments and reassessments were reviewed prior to and during the on-site audit. A current safe housing report was uploaded and indicated that all youths' assessments were current.

During interviews, two case managers responsible for risk screenings reported using the information from the intake-screening tool and the additional safe housing assessment to make room assignment decisions. They said they use the form, which contains the 11 items per this standard and ask youth each question within 72 hours of their arrival, but typically these questions are asked on the first day they arrive, and again if additional information is reported. They said they screen the youth and conducts reassessments every 90 days unless additional information is received or criteria for a reassessment sooner than 90 days are met. All youth reported being asked all of the 11 items within one to two days after their arrival. Fourteen said they had only been asked these questions once when they first arrived; however, only five of these youth stated they had been at the facility more than 90 days. The review of the reassessments indicated that all but two youth were reassessed within 72 hours of their arrival. One of these youth was reassessed two days late, and one had not been assessed since his placement at Cottrell on May 3, 2019. However, approximately three weeks after the on-site audit, the safe housing reassessment in CCS indicated the youth who was not reassessed was assessed on the first day he arrived. Additionally, although no youth was identified as having reported prior victimization, the auditor reviewed previous safe housing reassessments and determined that one youth was assigned to Cottrell who had reported prior victimization. His initial and subsequent reassessments included the youth's report of prior victimization; however, once he arrived to Cottrell, this information was not carried forward. During conversations with the Compliance Coordinator, the auditor and Coordinator determined that this information would be relevant during the youth's TJJD stay and should remain on the youths' reassessments, as this information would not change over time. The prior victimization reported by one youth was included in the updated reassessment, and going forward, this practice will be followed.

(b): The auditor reviewed each assessment and determined the intake assessment, safe housing assessment, and safe housing reassessment are objective screening instruments.

(c): The intake assessment and reassessment forms are used to obtain the 11 items per this standard. The staff members responsible for the screening could articulate details of the items the risk screening considers.

(d): The staff members who conduct the screening said they asks the youth questions from the screening during a conversation in their offices. One stated a case review is conducted and parents are contacted for additional information.

(e): TJJD policy establishes appropriate controls to prevent sensitive information obtained from these screenings from being exploited to the youth's detriment by staff or other youth. During interviews, facility staff members stated the information from the screenings is password protected and limited to medical and mental health care staff, the youth's case manager, and supervisory staff.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the resident's history is reviewed within 72 hours and periodically, b) the assessment is objective, c) the agency ascertains information about each of the items per this provision, d) the information is ascertained through conversation and records review, and e) the dissemination of information is controlled.

The auditor determined that each element of this standard is addressed, which supports compliance with provisions (a) – (e). Although not all youth reported being asked these questions throughout their stay at Cottrell, the auditor reviewed 10 risk assessments and concluded the assessments were conducted during intake and throughout the youth's confinement, which supports compliance with provision (a). The assessment procedures appear to be conducted in a similar manner for each youth, which supports compliance with provision (b). The auditor compared the assessment to the items in provision (c) and determined that each item is addressed, which supports compliance with this provision. During interviews, the case manager and youth reported that the intake process includes gleaning information through conversation. The case manager reported that a variety of data is reviewed and considered, which supports compliance with provision (d). Compliance with provision (e) was determined based on the area with limited access in which youth files are stored. Since the facility demonstrated compliance with all provisions, the auditor determined the facility meets the requirements of this Standard.

Corrective Action: None

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No
- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this Standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations

where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337(h)(2)
2. GAP 380.9745 (d)(2)
3. GAP 380.9739
4. Cottrell face-to-name form

Interviews:

1. Compliance Manager
2. Staff responsible for risk screening

Observations:

(a): TJJD policy requires that information obtained using the screening instrument is used to reassess housing and supervision assignments. The Compliance Manager and staff members responsible for risk screening stated the screening instrument is used to make room assignments. A face-to-name form showed that youth were assigned a rating of high, medium, or low, and the safe housing reassessments in the TJJD database included case manager notes indicating the youths' risk level.

(b): TJJD policy requires that 1) except under limited situations involving self-injury, TJJD does not place youth in isolation as a means of protection, 2) the placement of youth in protective custody is used only as a last resort, and 3) youth in protective custody receive all standard service delivery and programming requirements. The facility reported that no youth at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.

(c): TJJD policy requires that LGBTI youth are not placed in particular housing, beds, or other assignments on the basis of such identification. No youth who identified as LGBTI was present during the audit, but interviews with staff verified that this would be considered when assigning a room and bed.

(d): TJJD policy requires that for each transgender or intersex youth, TJJD makes a case-by-case determination when assigning the youth to a male or female facility. The auditor found that no youth who identify as transgender or intersex was placed at the facility during the on-site audit portion. The Compliance Manager said these decisions would be made on a case-by-case basis, and that housing decisions were made based on the screening reassessment data. No transgender youth was present at the facility on the day of the on-site audit or in the past 12 months.

(e): TJJD policy requires that placement and programming assignments are assessed at least twice per year. The Compliance Manager and staff responsible for risk screening said that youths' safety and security was considered when making room and bed assignments.

(f): TJJD policy requires TJJD to consider the youth's own views concerning his or her own safety when making placement and programming assignments. The Superintendent, Compliance Coordinator, and Compliance Manager corroborated this practice during interviews.

(g): TJJD policy requires that transgender or intersex youth are provided the opportunity to shower separately from other youth. Interviews with staff verified this would be the practice for these youth.

(h): The facility reported that no youth at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.
(i): TJJD policy exceeds the 30-day review requirement and requires that at least once every 48 hours following a youth's admission into protective custody, the designated mental health professional reviews the documentation relating to the protective custody, including the youth's treatment plan and any other documentation relating to the youth's stay in protective custody. No staff responsible for monitoring youth in isolation was interviewed, as the facility does not have rooms or areas used for this purpose.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency uses information gained pursuant to Standard 115.341 to make placement decisions designed to keep all residents safe; b) residents are isolated as a last resort and if they are isolated, resident receive access to exercise and education; c) LGBTI residents are not placed in specific housing based on this status; d) placement decisions are made on a case-by-case basis; e) placement decisions for transgender and intersex youth are reassessed twice per year; f) the views of transgender and intersex residents are given serious consideration; g) transgender and intersex are given the opportunity to shower separately; h) isolation of residents is documented; and i) residents held in isolation receive a review every 30 days.

The auditor reviewed TJJD policy and determined that all provisions are sufficiently addressed, which supports compliance with provisions (a) – (i). The auditor reviewed reassessments and the facility face-to-name form to confirm that ratings are assigned to each youth. The Compliance Manager stated that this information is used to determine bed/room assignments, which evidenced the implementation of provision (a). Staff members' and youths' responses during interviews confirmed that isolation is not used for protective custody, thus supporting compliance with provisions (b), (h), and (i). Staff responses during interviews supported compliance with provision (c). Since sufficient evidence was present to determine compliance with all provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☐ Yes ☒ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (i)
3. TJJD Youth Handbook
4. TJJD Employee Handbook

Interviews:

1. Random staff members
2. Random youth
3. Compliance Manager

Observations:

1. Posted hotline numbers in common areas

(a): TJJD policy requires that youth may report sexual abuse or harassment, retaliation, and staff neglect by: 1) filing a written grievance, 2) calling the OIG hotline, 3) telling a staff member, volunteer, or contract employee, or 4) calling the OIO. During interviews, youth were able to articulate the various ways to make a report, but many said they would not be able to do so privately or anonymously.

(b): TJJD policy requires that youth can make a report by "calling the toll-free number maintained by the Office of Independent Ombudsman (OIO), which is a separate state agency, without being heard by staff or other youth." During the facility inspection, OIO and the zero-tolerance posters were posted in prominent areas and included the toll-free numbers. These numbers are also included in the

youth handbook. The facility provided an MOU with a rape crisis center, but the agreement appears to be out of date, and the Director of the center was unaware of the MOU with Cottrell. Additional details about access to the crisis center and requested corrective actions are provided in standard 115.321.

During his interview, the Compliance Manager said that youth could report sexual abuse by calling the OIO. During interviews, youth were unaware of an outside reporting option and when prompted said they could tell their "mom." Several said they could call the OIO. None were certain about submitting an anonymous report, and most said they would be required to give their name and/or TJJD number.

The agency does not house residents detained solely for civil immigration purposes; therefore, the second portion of this provision is not applicable.

(c): TJJD policy requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must be promptly reported. A review of serious incident reports indicated allegations received verbally and through the youth grievance system were reported by staff members to the IRC. Youth articulated an understanding of the various reporting options, but most said they would not be able to report anonymously or privately.

(d): The facility provides youth access to the tools necessary to make a written report. During informal interviews with random youth and the youth grievance clerks, they said they had daily access to grievance forms and could drop the completed grievance into a locked box located in the day area. The auditor observed the OIG and OIO phone numbers posted throughout the facility.

(e): TJJD provides staff members the same reporting options as youth, and during interviews, they demonstrated an understanding of the ability to report anonymously and privately.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency provides multiple ways to privately report sexual abuse or harassment; b) residents are provided an anonymous reporting option to an outside entity, and residents detained for civil immigration shall be provided information on how to contact consular officials; c) staff shall accept verbal, written, anonymous, and third party reports and must document verbal reports; d) residents have the tools needed to make written reports; and e) staff have a method to privately report sexual abuse or harassment of residents.

The auditor reviewed determined that each element of this standard is included, which supports compliance with provisions (a) – (e). To support compliance with provisions (a) and (b), the auditor noted the hotline numbers posted in each dorm, conducted informal interviews with youth and staff and asked them to point out the posted numbers and to explain reporting options. One requirement of provision (b) is to allow youth to report anonymously. Since not all youth were aware of this option, additional education is recommended. A determination of compliance with provisions (c), (d), and (e)

was based on interview responses which included explanations of a variety of reporting options and the procedures for making reports. Additional evidence for provision (c) was contained in the incident and investigative reports. Each of these includes the documentation of verbal reports made by youth and subsequent reports made to the IRC. Since the facility demonstrated compliance with each provision, the auditor determined Cottrell meets the requirements of this standard.

Corrective Action: None

Recommendation:

1. Since most youth did not know they could report anonymously, provide additional education to make them aware of this option.

Actions Taken since the Interim Audit Report:

1. All staff at the McFadden Ranch will be retrained regarding these specific training components. Consistent refresher training will be a continued responsibility for the facility's PREA Compliance Manager and will be routinely monitored by the agency's PREA Coordinator for compliance.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this Standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this Standard.
  ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this Standard.)
  ☒ Yes ☐ No ☐ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this Standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this Standard.)☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this Standard.)
☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (i)
3. GAP 380.9331 (a)
4. Youth handbook
5. Youth Rights Policy (YRP) 05.05

Interviews:

1. Compliance Manager
2. Superintendent
3. Random youth
4. Random staff

Observations: No observations relative to this standard were required.

(a): TJJD policy outlines the administrative procedures for addressing youth reports regarding sexual abuse. Policy states that a youth may report sexual abuse/harassment, retaliation, staff neglect, or violations that may have contributed to such incidents by filing a written grievance, calling the IRC maintained by the OIG, calling the OIO, or telling a staff member, volunteer, or contractor who must then call the IRC.

(b): TJJD policy requires that the OIG and/or the AID investigate all allegations of sexual abuse regardless of how much time has passed since the alleged incident. The policy also states that youth are not required to use the grievance system or the informal conference request and are not required to attempt to resolve the allegation with staff. If a youth uses the grievance system or conference request, the allegation is immediately forwarded to the OIG for assignment and investigation. The youth handbook includes the following:

- Phone numbers for the OIG hotline and OIO
- Zero tolerance policy
- Overview of the PREA
- Definitions of sexual abuse
- Sexual abuse myths and realities
- Actions to take if a youth is abused
- Reporting options (tell a staff member, call one of the hotlines, write a grievance)

(c): TJJD policy requires that a grievance alleging sexual abuse or sexual harassment does not have to be submitted to the person who is the subject of the allegation and the allegation is referred to the staff member who is the subject of the complaint. The youth handbook contains details about the grievance process and includes information regarding the youth's right to submit a grievance. YRP policy states that at a halfway house, the assistant superintendent collects the grievances from a locked grievance box and in the absence of the assistant superintendent, the superintendent performs that duty. If a youth wishes to file a grievance against the superintendent or assistant superintendent, he or she may call the IRC or make a report to a different staff member.

(d): TJJD policy does not stipulate that a final decision on the merits of an allegation of sexual abuse or harassment be completed within 90 calendar days of the initial filing of the complaint. However, a directive from the Deputy Director of the AID stated "effective July 15, 2014 the AID revised the operating procedures to allow 60 business days (i.e. 90 calendar days) from the receipt of an allegation to final disposition of an administrative investigation. The investigator may request an extension up to 70 calendar days to complete the investigation.

The facility reported zero administrative investigations involving Cottrell staff during the reporting period and stated that no youth were assigned to the facility during the on-site audit who reported a sexual abuse, thus this targeted interview was not conducted.

(e): TJJD policy requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must be promptly reported. The agency grievance policy states that youth, parents/guardians of youth, and youth advocates have a right to file grievances concerning a youth under the jurisdiction of TJJD. The policy also states that any person may submit a grievance to the IRC by telephone, email, fax, or postal service. If a third party, other than a parent or guardian, files a request on behalf of a resident, the agency does not require as a condition of processing the request that the alleged victim to agree to have the request filed on his or her behalf. The auditor found no policy or documentation reviewed to contradict this. Additionally, when a parent or legal guardian files a request on behalf of a resident, the agency does not condition processing of the request upon the juvenile agreeing to have the request filed on his or her behalf. The auditor found no policy or documentation to contradict this. No third-party reports were submitted during the audit period; however, youth and staff members said that these types of complaints could be submitted and would be accepted by the facility and/or TJJD.

(f): TJJD policy states that upon receipt of a report that alleges a youth is subject to a substantial risk or imminent sexual abuse, TJJD takes immediate action to protect the youth. The facility reported

that there have been no emergency grievances alleging risk of imminent sexual abuse in the last 12 months.

(g): TJJD policy states that the "agency may not discipline a youth if the youth made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation." The youth handbook instructs youth not to lie and explains that false reports are crimes. The facility reported there have been no youth grievances alleging sexual abuse that resulted in disciplinary action by the agency against the youth for having filed a grievance.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency has administrative procedures for dealing with sexual abuse allegations; b) the agency does not impose a time limit to submit a grievance regarding sexual abuse, may apply time limits on a portion of the grievance that does not allege sexual abuse, shall not require the use of an informal grievance process, the agency's ability to defend against a lawsuit based on the statute of limitations; c) residents may submit a grievance without submitting it to eh staff member who is the subject of the complaint; d) the agency shall issue decisions about a allegations of sexual abuse within 90 days; a 70-day extension may be issued; if the resident does not receive a decision within the administrative process time limit, the resident may consider the absence of a response to be a denial at that level; e) third parties may assist residents in filing administrative remedies relating to sexual abuse; if third parties other than parents of guardians files such a request, the facility may require the alleged victim to agree to have the request filed on his/her behalf; if the resident does not agree, the facility must document the resident's decision; a parent may submit this request without the youth's agreeing to have the request filed on his/her behalf; f) the agency shall establish procedures for the filing of emergency grievances of imminent sexual abuse and immediate action must be taken to protect the resident; and (g) residents may be disciplined for alleging sexual abuse in bad faith.

The agency is not exempt from provision (a), as the facility has administrative procedures to address resident grievances regarding sexual abuse. The auditor reviewed TJJD policy, and although the language in the policy is not in exact alignment with the language in this standard, the auditor determined that policy and the AID directive explicitly and/or implicitly addresses all elements, which demonstrate compliance with provisions (a) – (g). Compliance with provision (b) and (c) was based on the auditor's review of the youth handbook and YRP policy, which contain information pursuant to these provisions. No third party or emergency reports were received during the audit period, so the auditor relied upon agency policy and interview responses, both of which indicated third party reports would be accepted, to determine compliance with provisions (e) and (f). The auditor determined compliance with provision (g) based on policy and the youth handbook, which include information regarding these types of grievances. Since the facility demonstrated compliance with all provisions, Cottrell meets the requirements of this standard.

Corrective Action: None

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?
  ☐ Yes ☒ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☐ Yes ☒ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☐ Yes ☒ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (i)
2. MOU with Advocacy Center for Crime Victims & Children in Waco, Texas
3. Youth handbook

Interviews:

1. Facility Superintendent
2. Director of the Advocacy Center for Crime Victims & Children
3. Random youth

Observations:

1. Youth phones

(a): TJJD policy requires that youth have access to outside victim advocates for emotional support services related to sexual abuse by making available mailing addresses and telephone numbers. The MOU between the crisis center and interview of the center's director indicated the MOU is out-of-date and/or no longer exists. More information is included above in standard 115.321. The auditor reviewed the handbook, which did not include the contact information or name of an outside rape crisis center.

During random youth interviews, none were aware of outside rape crisis or victim advocate services that specifically served Cottrell youth. Several named the OIO or their parents as the outside resources. While the OIO is an outside reporting option, this entity would not provide rape crisis services.

No interview with a youth who reported a sexual abuse was conducted, as none were assigned to the facility during the audit.

(b): TJJD policy requires that youth are informed, prior to giving them access, of the extent to which communications with outside services related to sexual abuse will be monitored and mandatorily reported. During interviews, staff members communicated understanding of mandatory reporting laws. Since youth lacked understanding of outside support services, they lacked understanding of the limits of confidentiality of these services.

(c): An MOU with a crisis center indicated a previous agreement was established to provide services. However, a previous TJJD Executive Director signed the MOU and no date was noted. Additionally, the auditor interviewed the Director of the crisis center who said she could not locate the MOU, was unaware of the MOU with Cottrell, and said the center would not provide services to youth in Dallas, as the distance to the center in Waco, Texas would be a barrier.

(d): TJJD policy requires reasonable and confidential access to youths' attorneys and parents or legal guardians. During interviews, youth said they received this access. The auditor observed youth phones, and confirmed by picking up the receiver, that the phones were operable.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall provide residents access to outside victim advocates related to sexual abuse, b) the facility inform residents of the extent to which communications are monitored and of mandatory reporting, c) the facility shall attempt to enter into an MOU with community service providers that provide residents with emotional support services, and d) the facility shall provide confidential access to legal representation. Although policy addresses each provision, based on youths' lack of knowledge of these services, and thus lack of knowledge of the limits of confidentiality, the auditor determined the facility did not demonstrate compliance with provisions (a) and (b).

The auditor relied upon interviews for additional evidence of compliance with provision (d). Staff members and youth explained that youth are consistently provided access to their attorneys and legal representation and may speak to them privately. Since the facility did not demonstrate compliance with provisions (a) and (b), Cottrell did not meet the requirements of this standard and corrective action was initiated.

Corrective Action:

1. Provide, post, or otherwise make accessible the address and telephone number to an outside advocate pursuant to provision (a).

2. Per provision (b), provide youth education regarding this access, the extent that such communications will be monitored, and the services related to sexual abuse available to them.

3. As requested in standard 115.321, provide an MOU with a crisis center to indicate that their services will be offered to all victims of sexual abuse, and if an MOU is not achieved, provide evidence of Cottrell's efforts to enter into such agreement.

Corrective Actions Taken since the Interim Audit Report:

On August 2, 2019, the auditor received notification that Cottrell House was permanently closed. The Compliance Coordinator provided the following information regarding corrective actions taken thus far.

1. All required postings will be made available to the youth from Cottrell Halfway House through their new housing location at McFadden Ranch.

2. The PREA Compliance Manager will ensure that all youth previously assigned to the Cottrell House who currently reside at the McFadden Ranch, are educated regarding the services provided through Abigail's Arms Cook County Family Center.

3. As previously stated, there is already an executed MOU with the Abigail's Arms Cook County Family Center which will serve the youth of the McFadden Ranch and subsequently those youth who were previously assigned to the Cottrell House.

Since the facility was permanently closed approximately two weeks after the auditor sent the interim report, the auditor was unable to conduct post-audit interviews with staff and youth and did not have sufficient time to determine whether the corrective actions had been institutionalized at Cottrell House. Thus, the auditor's initial determination of unmet for this standard remains unchanged in the final report.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (i)
2. TJJD website

Interviews: No interviews relative to this standard were required.

Observations: No observations relative to this standard were required.

(a): The TJJD website provides appropriate reporting options on its website. The primary referral option is through the IRC maintained by the OIG, but reports may also be made to the OIO, law enforcement agencies, Children's Protective Services, and to the facility directly.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall have a method to receive third-party reports. Since policy contains this information, compliance with this provision is supported. For additional evidence, the auditor visited the agency website pages, which inform the public about and contain links to reporting options. The auditor determined the facility meets the requirements of provision (a), and thus this standard.

Corrective Action: None

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Employee handbook
3. GAP 380.9337(j), (1)

Interviews:

1. Superintendent
2. Compliance Manager
3. PREA Compliance Coordinator
4. Director of Nursing
5. Random staff

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that staff members must immediately report to the OIG any knowledge, suspicion, or information received regarding an incident of sexual abuse or sexual harassment. They are also required to report any incident of retaliation against youth or staff who reported such incidents as well as any staff neglect or violation of responsibilities that may have contributed to such

an incident. This policy applies to any facility, whether or not it is operated by TJJD. Interviews with staff demonstrated their knowledge of their reporting responsibilities under Texas law, facility policy, and PREA regulations.

(b): TJJD policy requires that all staff members must comply with mandatory child abuse reporting laws in the Texas Family Code and with applicable professional licensure requirements. Interviews with staff indicate they are aware of and understand mandatory reporting laws and hole required licenses.

(c): TJJD policy requires that all staff members who receive a report of alleged sexual abuse is prohibited from revealing that information to anyone other than to the extent necessary. Interviews with staff demonstrated they understand the requirements for the handling of sensitive youth information. They said they received the information during new hire, annual training, and dorm reviews.

(d): TJJD policy requires medical, mental health staff, clergy and attorneys whose communications may otherwise be privileged to report abuse as required by law and to inform youth of the limitations of confidentiality. Interviews with medical and mental health care staff confirmed compliance with this standard relating to protection of confidential information and required disclosures.

(e): TJJD policy requires that the facility administrator must promptly report any allegation of alleged sexual abuse to the youth's parents or legal guardians. If the alleged victim is under the conservatorship of DFPS, the report is made to DFPS. No reports of this type were necessary during the audit period, but the Superintendent demonstrated her knowledge of this requirement during her interview.

(f): TJJD policy requires that all staff members must immediately report all allegations of sexual abuse and sexual harassment to the OIG. OIG assigns all reports of alleged sexual abuse and sexual harassment, including third-party and anonymous reports, to the appropriate investigator. Interviews with the OIG investigator and the Superintendent confirmed this is the practice. They stated that all reports are submitted to the IRC, which is monitored by OIG. The auditor reviewed IRC documentation to confirm that serious incidents were reported to the OIG.

Summary of Findings:

The auditors assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall require staff to report any knowledge, suspicion, or information regarding sexual abuse, retaliation, and neglect; b) the agency shall require staff to comply with mandatory reporting laws; c) staff shall not reveal information regarding sexual abuse incidents other than to the extent necessary; d) medical and mental health staff must report sexual abuse to supervisors, state and local agencies where required by mandatory reporting laws and inform residents of the limitations of confidentiality; e) upon receiving a sexual abuse allegation, the facility head or designee must report to appropriate agencies, and the resident's parents, caseworker, legal

guardian, or legal representative; and f) the facility shall report sexual abuse allegations to investigators.

The auditor reviewed TJJD policy and concluded that each element is addressed, which supports compliance with provisions (a) – (f). Evidence relied upon to determine compliance with provisions (a) and (b) was based upon interviews with staff members who communicated an understanding of their reporting duties. Compliance with provision (c) was determined through interviews, during which staff members communicated their understanding of protecting information related to sexual abuse reports. Evidence for provision (d) was based on staff medical and mental health staff members' understanding of mandatory reporting. Compliance with provisions (d) and (e) was also based on interviews, during which staff members articulated knowledge of their reporting duties and understood to whom they would report any information regarding sexual abuse. The auditor reviewed serious incidents that were reported to the IRC and subsequently assigned to determine compliance with provision (f). Since TJJD and Cottrell demonstrated compliance with each provision, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)

Interviews:

1. Superintendent
2. TJJD Executive Director
3. Compliance Coordinator
4. Random staff

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that upon receipt of an allegation that a youth is subject to a substantial risk of imminent sexual abuse, TJJD must take immediate action to protect the youth. The agency reported that there have been no instances of this in the past 12 months. All staff members interviewed were able to explain precautions that would be taken to protect a youth at risk of imminent sexual abuse. The Executive Director said if a staff member learned that a youth was at substantial risk of sexual abuse, the staff member would remove the youth the threat, reassign the adult, place a buffer zone between the youth and the threat, and monitor for retaliation for at least 90 days. She said these actions would be taken immediately.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) when an agency learns a resident is at risk of imminent sexual abuse, immediate action to protect the resident must be taken. The auditor reviewed policy and determined this provision is addressed. Since an incident of this type did not occur during the audit period, the auditor relied on staff members' responses during interviews and assessed their knowledge regarding the actions that would be taken if this should occur. Staff members communicated an understanding of these actions per this standard and the facility coordinated response plan and were able to articulate specific and immediate actions they would take. The auditor determined the facility meets the requirements of provision (a), and thus this Standard.

Corrective Action: None

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these Standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. GAP 380.9337 (k),(1)
4. Investigation summaries
5. Documentation that no SARBs were conducted during the audit period

Interviews:

1. Superintendent
2. Compliance Manager
3. TJJD Executive Director

(a): TJJD policy requires that any staff member who receives an allegation that a youth was sexually abused while confined at another facility must immediately notify the OIG, and the OIG must notify the head of the facility where the abuse occurred. The Executive Director confirmed her knowledge of this requirement during her interview. The facility reported there were no allegations of this type received in the past 12 months.

(b): TJJD policy requires that the notification will be provided as soon as possible but no later than 72 hours after receiving the allegation.

(c): No allegations were received; therefore, no notifications were provided.

(d): TJJD policy does not contain the TJJD's guidelines requiring that allegations received from other facilities/agencies are investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) upon receiving an allegation of sexual abuse that occurred at another facility, the facility head notifies the facility head or appropriate office where the alleged abuse occurred; b) the notification shall be provided immediately but no later than 72 hours after receiving the allegation; c) the notification shall be documented; and d) the facility head or agency office shall ensure the allegation is investigated.

Since no allegations of this type were reported during the audit period, the auditor relied upon policy and interview responses for all provisions. The auditor determined that each provision except (d) is addressed in policy. The interview responses of the Superintendent and TJJD Executive Director confirmed their knowledge of documentation and reporting responsibilities when a sexual abuse allegation is received from another facility. Thus, the facility demonstrated compliance with provisions (a) – (c). The auditor determined the facility meets the requirements of all provisions, and thus this standard.

Corrective Action: None

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
  ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?
  ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?
  ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Coordinated response plan

Interviews:

1. Security staff and non-security staff first responders
2. Random staff

Observations: No observations relative to this standard were required.

(a): TJJD policy and coordinated response plan contains all of the required elements of the first responder duties outlined in this standard. Interviews with staff members indicate an understanding of their first responder duties and were able to describe the procedures that would be followed to protect the youth and the crime scene. The facility reported no informal grievances alleged sexual abuse.

(b): TJJD policy outlines the actions to be taken by the first staff member who learns of an allegation that a youth was sexually abused. Cottrell staff members could articulate their first responder duties.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) upon learning that a resident was sexually abused, the first responder must separate the alleged victim and abuser, preserve the scene and collect evidence, collect physical evidence if the abuse occurred within a time period that this evidence may be collected, and ensure physical evidence is protected; and b) if the first responder is not a security staff, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff. The auditor determined that TJJD policy and the coordinated response plan contain each of these elements, which supports compliance with provisions (a) and (b). Interviews responses revealed additional evidence of compliance, as staff members communicated an understanding of the actions they would take following an allegation of sexual abuse. Since the facility demonstrated compliance with both provisions, the auditor determined Cottrell meets the requirements of this standard.

Corrective Action: None

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.
Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Coordinated response plan

Interviews:

1. Superintendent

Observations: No observations relative to this standard were required.

(a): The facility maintains a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for first responders, on-duty supervisors, medical and mental health care staff, investigators, facility leadership, sexual abuse review board members, and the Compliance Manager. The duties outlined in the plan require the first responder to notify the on-duty supervisor, notify infirmary staff, and report the allegation to the IRC and chief local administrator. The on-duty supervisor is responsible for separating the alleged perpetrator and alleged victim and securing the crime scene. The actions outlined in GAP 380.9337 (j) require the first responder to

separate the alleged victim and alleged abuser, preserve the crime scene, and take additional actions if the allege abuse occurs within a timeframe that allows for the collection of physical evidence. The Institutional Operations Manual (INS 71.01) requires actions, which align with the written institutional plan. The Superintendent demonstrated knowledge of the details in policy and the coordinated response plan.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall develop a written institutional plan to coordinate actions in response to an incident of sexual abuse. The auditor determined the facility policy contains details regarding this provision. Additional support of compliance was determined following a review of the Cottrell coordinated response plan, which includes actions to be taken by various staff members. During her interview, the Superintendent demonstrated comprehension of the plan. The auditor concluded that the facility meets the requirements of provision (a), and thus meets the requirements of this standard.

Corrective Action: None

Standard 115.366: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ

Interviews:

1. TJJD Executive Director
2. Compliance Coordinator

(a): TJJD meets the requirements of this subsection as TJJD does not enter into collective bargaining agreements that would limit TJJD's ability to remove alleged staff sexual abusers from contact with any youth pending an investigation determination.

(b): Cottrell meets the requirements of this standard as the facility does not enter into collective bargaining agreements.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall not enter into a collective bargaining agreement that limits the agency's ability to remove alleged abusers from contact with residents pending the outcome of investigation or disciplinary actions. Provision (b) is not required to be audited. Since TJJD policy contains language pursuant to provision (a), and provision (b) is not required to be audited, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Coordinated response plan
4. Agency Protection Against Retaliation PREA Monitoring Form

Interviews:

1. TJJD Executive Director
2. Superintendent
3. Compliance Coordinator
4. Staff who monitor for retaliation
5. Youth who reported a sexual abuse

Observations: No observation relative to this standard was required.

(a): TJJD policy prohibits retaliation by a youth or staff member against a youth or staff member who reports or cooperates with an investigation. Certain staff members are designated to monitor the person who reported the allegation and the alleged victim for possible retaliation. The facility reported that there have been no incidents of retaliation that have occurred in the past 12 months.

(b): The TJJD uses multiple protection measures to protect youth and staff from retaliation, such as housing transfers, transfers of youth, removal of alleged abuser from contact with the alleged abuser, and emotional support services. Staff members were able to articulate actions utilized to protect youth and staff members and monitor for retaliation. The Superintendent said measures could include bed assignment changes, implementing boundary and safety plans, utilizing the monitoring form, or reporting suspected retaliation to the IRC. The auditor was unable to review monitoring forms, because none were needed during the audit period. The Executive Director said that she notified staff members in an email that retaliation for reporting could result in termination. She also said that the staff member would be removed and the youth monitored for at least 90 days and placed on a safety plan. The Cottrell staff members responsible for monitoring communicated their understanding of this provision and stated they would initiate and maintain contact with the youth, provide opportunities for the youth to speak with them privately, and update their safe housing plans.

(c): TJJD policy requires the agency to continue monitoring for retaliation for at least 90 days following a report, except when the allegation is determined to be unfounded. An extension of more than 90 days is possible if needed. The Superintendent, Compliance Manger, and one facility staff member responsible for monitoring were knowledgeable about the duty to monitor for retaliation for at least 90 days. They said this time would be extended if needed, as there is no maximum time for monitoring efforts. One staff member responsible for monitoring for retaliation did not demonstrate an understanding of this provision and timelines. No completed monitoring forms were reviewed, as no monitoring was needed during the audit period. However, a template titled Agency Protection Against Retaliation PREA Monitoring Form was reviewed and contained spaces for the name of the monitor and youth, date of the incident, beginning date, expected ending date, and comments.

(d): TJJD policy requires that staff members conduct periodic status checks of the alleged victim. One facility staff member responsible for monitoring for retaliation stated there is no maximum length of time a youth would be monitored and the other was not sure.

(e): TJJD policy requires that staff take appropriate measures to protect any other individual who cooperates with the investigation who may be at risk of retaliation or who expresses a fear of

retaliation. The Superintendent said that monitoring would be documented on the monitoring form, that staff members would watch for changes in youth behavior that might indicate he was being retaliated against, place the youth on a safety plan, and maintain frequent contact with the youth. She stated there is no maximum time that these actions would be taken. The TJJD Executive Director said that if any individual expressed fear of retaliation, the youth would be separated from the threat and placed on a safety plan.

(f): TJJD policy requires that the agency's obligation to monitor shall terminate if the investigation determines the allegation is unfounded.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency establishes policy to protect residents and staff from retaliation, b) the agency shall use multiple protection measures, c) the agency shall monitor for retaliation for at least 90 days, d) monitoring shall include periodic status checks, and e) if any individual expresses fear of retaliation, the agency takes steps to protect the individual. The auditor is not required to audit provision (f).

The auditor determined that TJJD policy contains each provision, which demonstrates compliance with provisions (a)-(f). Evidence of compliance with provision (a) includes the facility's designation of staff members who are responsible for retaliation monitoring. Evidence of compliance with provisions (b) – (e), was determined after reviewing interview responses. One retaliation monitoring staff member communicated an understanding of the monitoring duties and the required timelines. The Compliance Manager, Superintendent, and Executive Director described actions that would be utilized to protect youth or staff who feared retaliation. Compliance with these provisions was further demonstrated during a review of the extensive documentation of these efforts to monitor for retaliation. Since the facility demonstrated compliance with all provisions, the auditor determined the Cottrell meets the requirements of this standard.

Corrective Action: None

Recommendation:

1. Since one staff member was unsure of the retaliation monitoring duties and timelines, provide a refresher training to any staff member who may be responsible for monitoring for retaliation.

Actions Taken since the Interim Audit Report:

1. All case managers or supervisors who are responsible for PREA retaliation monitoring will be provided with semi-annual or quarterly training to ensure that they remain abreast of the requirements for this procedure in accordance with PREA.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)

Interviews:

1. Superintendent
2. Medical and mental health care staff

Observations:

1. Confirmation during the facility inspection that no isolation cells/rooms are present

(a): TJJD policy prohibits using segregated housing to protect a youth who is alleged to have suffered sexual abuse. Cottrell does not have isolation cells and thus does not use isolation to protect youth who have alleged to suffer a sexual abuse. When asked the relevant questions per this standard, the

Superintendent confirmed that the questions were not applicable, as Cottrell does not have cells or rooms used for isolation.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) any segregated housing used to protect a resident alleged to have suffered sexual abuse shall be subject to the requirements in standard 115.342. The auditor's determination of compliance with this provision was based on policy review, interview responses, and observations during the facility walk through. The policy contains details regarding provision (a), and staff members reported that this type of segregation is not used. No youth were placed in isolation pursuant to this standard during the facility inspection. Additional support of compliance was based on youths' responses, which confirmed that this or any type of isolation is not used. Since Cottrell is compliant with provision (a), the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. Training records for investigators

Interviews:

1. Superintendent
2. Random staff
3. AID Investigator
4. OIG Investigator

Observations: No observations were required relative to this standard.

(a): TJJD policy requires that investigations will be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports. Both investigators said that once reports, including third-party reports, alleging sexual abuse are received, an investigation would be initiated within 24 hours. No investigative records were reviewed, as no investigations pursuant to this standard were conducted during the audit reporting period.

(b): TJJD policy requires that it will use investigators who have received special training in sexual abuse investigations involving juvenile victims per standard 115.334. All investigators have received certifications for completed training from the NIC. Investigators interviewed demonstrated their understanding of interviewing youth, evidence collection in confinement settings, and criteria needed to substantiate a case.

(c): TJJD policy requires that investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence. They will include any available electronic monitoring data, interview appropriate persons, and review prior complaints involving the alleged perpetrator. Interviews with investigative staff demonstrated their knowledge of conducting investigations of this type. No investigative records were reviewed, as no investigations pursuant to this standard were conducted during the audit reporting period. The State of Texas Retention Schedule for TJJD investigative files states that AID files are retained for five years after the case is closed. OIG criminal investigative files are retained for 20 – 50 years depending on the type of case.

(d): TJJD policy requires that investigations will not be terminated because the source of the allegation recants the allegation. The investigators supported compliance with this standard stating that an investigation would not end due to an allegation being recanted.

(e): TJJD policy requires that when the evidence supports criminal prosecution, compelled interviews may be used, but only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The AID and OIG investigators stated OIG would conduct compelled interviews only if there was sufficient evidence to do so. No AID investigative records were reviewed, as no administrative investigations were conducted during the audit period. Criminal reports were not reviewed, as OIG is considered an outside investigative entity.

(f): TJJD policy requires investigators to assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the person's status as a youth or staff. The policy states they do not require youth who allege sexual abuse to submit to a polygraph or other truth-telling device as a condition for proceeding with the investigation. Interviews with two investigators confirmed understanding of and compliance with this practice.

(g): TJJD policy requires that administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. Additionally, policy requires investigators to document the investigation in written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings. No AID investigative records were reviewed, as no administrative investigations were conducted during the audit period.

(h): TJJD policy requires criminal investigations conducted by OIG to be documented in a written report that includes the evidence and attach copies of documentary evidence where possible. Criminal reports were not reviewed, as OIG is considered an outside investigative entity.

(i): TJJD policy requires that substantiated allegations of conduct that appear to be criminal are referred for prosecution. The OIG PAQ states that there have been no substantiated allegations of conduct which appeared to be criminal and, therefore, were referred for prosecution since the last PREA audit.

(j): TJJD policy requires the agency to retain all written administrative investigative reports for as long as the alleged abuser is incarcerated or employed by the agency, which aligns with The State of Texas Retention Schedule for TJJD administrative investigative files.

(k): TJJD does not terminate investigations solely on the basis that the alleged abuser or victim is no longer with the agency. The AID and OIG investigators said the investigation would continue regardless if the alleged abuser or victim is no longer employed or placed at Cottrell.

(l): According to TJJD policy, OIG follows the above provisions.

(m): TJJD policy requires that staff members cooperate with outside agencies that conduct investigations and remain informed about the progress of the investigations. During interviews, the Superintendent, Compliance Manager, and Compliance Coordinator stated that overall, the investigators would keep them informed. The OIG investigator stated that during investigations, relevant information would be relayed to the facility.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency conducts thorough and prompt investigations; b) investigators must have specialized training; c) investigators shall gather evidence and shall review prior complaints involving the suspected perpetrator; d) the investigation continues if the complainant recants the allegation; e) the agency conducts compelled interviews only after consulting with prosecutors; f) the credibility of the alleged victim shall be assessed on a case-by-case basis, and no polygraphs or truth-telling devices are used as a condition of continuing the investigation; g) administrative investigations shall include the consideration of staff actions and shall be documented in written reports; h) criminal investigations shall be documented in written reports; i) substantiated allegations that appear criminal shall be referred for prosecution; j) the agency maintains all written reports as long as the alleged abuser is incarcerated or employed by the agency plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention; k) the departure of the alleged abuser or victim from the facility or from employment shall not provide a basis for terminating an investigation; and m) the facility cooperates with outside investigators. Provision (l) is not required to be audited.

The auditor determined that the TJJD policy addresses each of these provisions, which supports compliance with provisions (a) – (m). Compliance with provision (b) was based on certificates of completion of the specialized training the investigators received. Compliance with provision (d) was determined, as no youth recanted his allegation, and no administrative investigation were conducted or resulted in a referral for prosecution. Compliance with provision (f) was based on the investigators' responses during interviews. Compliance with provisions (a) – (m) was based on interview responses, which revealed an understanding of the requirements of each provision. Since policy, interview responses, and investigative reports demonstrated compliance with each provision, the auditor determined Cottrell meets the requirements of this Standard.

Corrective Action: None

Standard 115.372: Evidentiary Standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a Standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)

Interviews:

1. Administrative investigator

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that the standard of proof used by the agency in administrative investigations is a preponderance of the evidence. The interview with the AID investigator confirmed his knowledge of the required standard of proof and that his practice was to use "preponderance of the evidence" in investigations. No investigative reports were reviewed, as none were conducted during the audit reporting period.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency standard to substantiate a case is a preponderance of the evidence. Policy addresses this standard, and the investigator communicated an understanding of this provision; therefore, the auditor determined Cottrell meets the requirements of this standard.

Corrective Action: None

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?
  ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?
  ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
  ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
  ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)

Interviews:

1. Superintendent
2. OIG Investigator

3. AID Investigator

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that until the youth is discharged from TJJD, the facility will inform the youth whether the allegation is substantiated, unsubstantiated, or unfounded. During their interviews, one investigator who was recently hired demonstrated in-depth knowledge regarding conducting investigations, but he was uncertain about informing youth about the outcomes of investigations. He stated he had read through policy and would know where to find the information should he need it. The other investigator said he was aware of this process. Since no investigations were conducted at Cottrell in the previous 12 months, no notifications were available for review.

(b): In the past 12 months, the AID, OIG, or other outside entity have not conducted any administrative or criminal PREA-related investigations. Since no investigations were conducted, no youth notifications could be reviewed.

(c): TJJD policy requires that youth are notified when 1) the staff member is no longer posted within the youth's unit, 2) the staff member is no longer employed at the facility, 3) when the staff member has been indicted, or 4) when the staff member has been convicted on a charge related to sexual abuse within the facility. There were no cases in which a staff member was confirmed to have violated a rule, thus no documentation of complaints or notifications could be reviewed.

(d): TJJD policy requires that following a youth's allegation that he or she was sexually abused by another youth, TJJD informs the youth when 1) the abuser has been indicted, or 2) the abuser has been convicted on a charge related to sexual abuse. Since no cases pursuant to this provision were opened, no notifications were made. No youth who had reported sexual abuse was assigned to the facility during the on-site audit.

(e): TJJD policy does not require documentation on all such notifications or attempted notifications under this standard. Since the OIG is an outside investigative entity, this standard was not audited.

(f): TJJD policy requires that the notification obligations of this standard apply until the youth is discharged from TJJD.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) following an investigation, the agency shall inform the resident of the outcome; c) the agency informs the resident when the staff member is no longer posted in the resident's unit, the staff member is no longer employed at the facility, the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility, or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility; d) following a resident's allegation that he or she has been sexually abused by another resident, the agency informs the alleged victim whenever the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility; and e) notifications are documented. Provision (e) was not audited,

as the OIG is considered an outside investigating entity. The auditor determined TJJD policy addresses each audited provision, which supports compliance with each applicable provision. No cases were opened during the audit period, thus investigative reports and resulting notifications were not reviewed. Since the facility demonstrated compliance with each provision, the auditor determined Cottrell meets the requirements of this standard.

Corrective Action: None

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (l)
3. Employee handbook
4. Memo from the Assistant Superintendent

Interviews: No interviews protocols are directly related to this standard.

Observations: Shower areas and live video

(a): TJJD policy requires that staff members who violate the agency's sexual abuse or sexual harassment policies are subject to disciplinary sanctions up to and including termination.

(b): TJJD policy requires that termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse. This information is also included in the employee handbook. In the past 12 months, the facility reported and a signed and dated memo from the Assistant Superintendent indicated that zero staff members have violated the TJJD policy on sexual abuse or sexual harassment, and none were terminated.

(c): TJJD policy requires that disciplinary sanctions will be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The facility reported zero instances of a staff member being disciplined, short of termination, for violating the agency's sexual abuse or sexual harassment policy. During the facility inspection, the shower areas provided sufficient privacy and would not allow the youth to be viewed while in this area.

(d): TJJD policy requires reporting the following actions to licensing bodies 1) terminations of employment for violations of TJJD sexual abuse or sexual harassment policies, and 2) resignations by staff members who would have been terminated if they had not resigned. The PAQ indicated that no staff members were reported to law enforcement or licensing boards for violating the agency's sexual abuse or sexual harassment policy.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) staff shall be subject to disciplinary sanctions up to and including termination for violations of PREA policy, b) termination is the presumptive sanction for sexual abuse, c) sanctions are commensurate with the nature of the violation, and d) terminations for PREA violations shall be reported to law enforcement agencies. Policy addresses all provisions, which evidences compliance with this standard, thus, the auditor concluded that Cottrell meets the requirements of this standard.

Corrective Action: None

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (l)
3. Memo from the Assistant Superintendent

Interviews:

1. Superintendent

(a): TJJD policy requires that if a contractor or volunteer engages in sexual abuse, TJJD prohibits the contractor or volunteer from having contact with youth and shall report the finding of abuse to relevant licensing bodies. In the past 12 months, the facility PAQ indicated that no contractors or volunteers have been reported to law enforcement for engaging in sexual abuse of youth. A memo from the Assistant Superintendent states that Cottrell has had no contractor or volunteer services postponed or terminated due to violations of PREA-related allegations or investigations in the past 12 months.

(b): TJJD policy requires that if a volunteer or contractor violates sexual abuse or sexual harassment policy, but does not actually engage in sexual abuse, TJJD will take appropriate remedial measures and considers whether to prohibit further contact. The facility reported no cases of a volunteer or contractor who was disciplined for policy violation. During her interview, the Superintendent stated that if a contractor or volunteer violated agency PREA policy, he or she would be restricted from campus, the incident reported to the IRC, and an investigation assigned to OIG or AID.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) contractors or volunteers who violate PREA policy shall be prohibited from contact with residents and reported to law enforcement agencies if the activity was criminal and b) the facility shall take appropriate remedial measures in the case of any other violation of agency sexual abuse or harassment policies by a contractor or volunteer.

Since the facility reported no instances of volunteer or contractor PREA violations, the auditor determined compliance based on policy review and interview responses. TJJD policy addresses both provisions. The Superintendent's responses provided additional evidence of compliance, as she communicated knowledge of actions that would be taken following a PREA violation by a contractor or volunteer. Since compliance was demonstrated with both provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (l)
3. GAP 380.9555
4. GAP 380.9503

Interviews:

1. Superintendent
2. Medical and mental health staff

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that a youth may be subject to disciplinary sanctions only after a substantiated finding in an administrative investigation or a criminal finding that a youth participated in the sexual abuse of another youth or staff member. The facility reported that there have been zero administrative findings and zero criminal findings of youth-on-youth sexual abuse that occurred in the facility in the past 12 months. The youth handbook includes descriptions of the discipline process including major and minor rule violations, consequences, and the right to due process and appeals.

(b): TJJD policy requires that disciplinary sanctions must be commensurate with the nature and circumstances of the abuse committed, the youth's disciplinary history, and the sanctions imposed for comparable offenses by other youth with similar histories. Discipline is determined through a Level II due process hearing held in accordance with GAP 380.9555. The Superintendent said sanctions could include a youth recommitment, criminal proceedings, loss of privileges, or additional required treatment for the youth. The Compliance Manager also demonstrated knowledge of the disciplinary

process. The facility reported that in the past 12 months, there have been no youth placed in isolation as a disciplinary sanction for youth-on-youth sexual abuse.

(c): TJJD policy requires that the disciplinary process consider whether a youth's mental disability or mental illness contributed to his or her behavior. The interview with the Superintendent and medical and mental health care staff indicated this is the practice when determining youth sanctions.

(d): TJJD policy requires that the facility offer counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. TJJD may require participation as a condition of access to behavior-based incentives, but not as a condition to access general programming or education. Medical and mental health care staff members said counseling and therapy is offered to youth offenders and victims.

(e): TJJD policy requires that a youth may be disciplined for sexual contact with staff only upon a finding that the staff did not consent to such contact. This is preceded by a criminal investigation by the OIG.

(f): TJJD policy requires that a youth may not be disciplined if the youth made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

(g): TJJD policy prohibits all sexual activity between youth and may discipline a youth in accordance with GAP 380.9503 for engaging in sexual activity that meets the definition of abuse. Regardless of the conduct, all sexual misbehaviors are included in the agency data collection.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this Standard and the PREA Audit Tool, which require that: a) residents may be subject to sanction only pursuant to a formal disciplinary process; b) sanctions shall be commensurate with the circumstances of the abuse committed, and the facility must provide specific services to residents who receive sanctions resulting in isolation; c) the disciplinary process shall consider a resident's mental disability when determining sanctions; d) if the facility offers therapy, counseling, and other interventions, the facility shall consider whether to offer the services to the offender, and the agency may require participation in such interventions as a conditions of access to rewards-based incentives but not as a condition to access to general programming; e) the agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did no consent; f) reports made in good faith shall not constitute false reporting; and g) the agency may prohibit all sexual activity between residents, may discipline resident s for such activity, and may not deem the activity sexual abuse if it determines that the activity is not coerced.

The auditor determined that TJJD policy addresses each provision, which demonstrates compliance with all provisions. Staff members' interview responses confirmed their knowledge of the

disciplinary and sanction process. Since the facility demonstrated compliance with all provisions, the auditor determined Cottrell meets the requirements of this standard.

Corrective Action: None

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)
3. Intake screenings
4. Psychological evaluation

Interviews:

1. Medical and mental health care staff
2. Youth who reported prior sexual abuse during screening

Observations:

1. The area where youth files are stored was described to the auditor following the audit, as the auditor did not view this area during the audit.

(a): TJJD policy requires that regardless of the intake screening results, the facility shall offer all youth, including youth offenders, a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. Although no youth was identified as having reported prior victimization, the auditor reviewed previous safe housing reassessments and determined that one youth was assigned to Cottrell who had reported prior victimization. His psychological evaluation was requested and reviewed following the audit. Psychological assessments, treatment notes, and resulting mental health services such as trauma counseling, mental health treatment, and sexual behavior treatment showed that these services occurred within 14 days for the youth disclosed he had been a victim. The youth stated during his interview that he had received timely and sufficient mental health care services.

(b): TJJD policy requires that any information obtained related to sexual victimization or abusiveness that occurred in an institutional setting must be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions including housing, bed, work, education and program assignments, or the facility in which they are placed. During interviews, the staff member responsible for the screening stated that follow-up services were provided immediately. Secondary materials are discussed in the provision above.

(c): Youth files are stored in a locked case manager's office. Limited staff members have access to these files. Medical information is stored in the Electronic Medical Records system through University of Texas Medical Branch, which also has limited access and is password protected.

(d): TJJD policy requires that staff members must obtain informed consent from youth age 18 or over before reporting information about prior sexual victimization that did not occur in an institutional setting. Interviews with mental health staff indicate that informed consent is obtained.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) if the intake screening indicates the resident has experienced prior sexual victimization, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; b) if the screening indicates the resident has previously perpetrated sexual abuse, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; c) any information related to sexual abuse or victimization shall be strictly controlled; and d) medical and mental health practitioners shall obtain informed consent before reporting information about prior victimization that did not occur in an institution, unless the resident is under the age of 18.

TJJD policy addresses each provision, which supports compliance with provisions (a) – (d). Compliance with provisions (a) and (b) was demonstrated during a review of the psychological assessment and subsequent actions taken based on the screening information. The youth who said he received mental health services also demonstrated compliance with these provisions. Compliance with provision (c) was demonstrated during interviews, during which staff members explained the limited access to resident files containing sensitive information. The auditor determined additional compliance with provision (d) during an interview with the Director of Nursing who communicated an understanding of informed consent. Since the facility demonstrated compliance with all provisions, the auditor determined that Cottrell meets the requirements of this standard

Corrective Action: None

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted Standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? 312 ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and

the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)
3. INS.71.01
4. Medical mental health records
5. Coordinated response plan

Interviews:

1. Medical and mental health care staff
2. Staff who conduct risk assessments

Observations:

1. Since youth receive medical and mental health care off site, this area was not observed.

(a): TJJD policy requires that youth victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners per their professional judgment. During interviews, the Gainesville State School Director of Nursing stated that youth victims receive access to these services and that OIG determines if the youth will be transported to a hospital for a SAFE/SANE. According to the coordinated response plan and INS, infirmary staff assesses the youth for injuries associated with the alleged sexual abuse, but OIG determines whether the youth will be transported to an off-site clinic for examination and treatment. Once the youth arrives to the off-site hospital, the SAFE/SANE nurse would determine further medical services.

(b): TJJD policy requires that if no qualified medical or mental health practitioners are on duty at the time of a report of recent abuse, staff first responders must take preliminary steps to protect the victim pursuant to standard 115.362 and shall immediately notify the appropriate medical and mental health practitioners. Interviews with staff demonstrated their knowledge of first responder protocols and procedures for cases of sexual abuse. The coordinated response plan includes the notification of medical and mental health care staff as a first responder duty.

(c): TJJD policy requires that the facility offers youth victims of sexual abuse timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care, and where medically appropriate. During interviews, the Director of Nursing said that the infirmary did not test for STDs, and if a youth was sexually abused, the testing would occur during the forensic exam.

(d): TJJD policy requires that the facility shall offer these treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any

investigation arising out of the incident. Interviews corroborated that victims are not charged for these treatment services.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) resident victims of sexual abuse shall receive access to emergency medical treatment and crisis interventions as determined by medical and mental health practitioners; b) if no qualified staff members are on duty at the time of report of recent abuse, the first responder shall take steps pursuant to standard 115.362 to protect the resident; c) resident victims of sexual abuse while incarcerated shall be offered information and access to emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted Standards of care; and d) treatment shall be provided at no cost to the resident.

The auditor determined that TJJD policy addresses each element of this standard, which demonstrates compliance with provisions (a) – (d). Policy aligns with provision (a), and the coordinated response and INS contain information about the decision-making process regarding emergency medical treatment for victims of sexual abuse.

The services described in this standard were not utilized during the audit period; however, youth files provided sufficient evidence that medical and mental health care services are provided to all youth at no charge. Additional evidence supporting compliance with provisions (b), (c), and (d) was based on interview responses. Staff members articulated their knowledge of the general medical and mental health care services all youth receive and emergency services that would be provided if needed. Youth also confirmed that they receive general medical and mental health care services at no cost.

Corrective Action: None

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)

Interviews:

1. Medical and mental health care staff
2. Staff who conduct risk assessments

Observations:

2. Since youth receive medical and mental health care off site, this area was not observed.

(a): TJJD offers medical and mental health evaluations and, as appropriate, treatment to all youth who are victims of sexual abuse in any facility. Interviews with medical and mental health staff indicated all youth undergo a screening during intake and periodically throughout their stay and receive follow-up services as needed. The auditor reviewed psychological assessments to ensure documentation of initial and on-going medical and mental health care services.

(b): TJJD policy requires that the evaluation and treatment of victims include follow-up services, treatment plans, and referrals for continued care following a youth's transfer to other facilities or release from custody. Medical and mental health care staff members said counseling and therapy was offered to youth offenders and victims.

(c): During interviews, medical and mental health care staff reported the level of care received at Cottrell and the University of Texas Medical Branch is consistent with or exceed the community level of care.

(d): TJJD policy requires that pregnancy tests are offered to youth victims of sexually abusive vaginal penetration that occurs while they are incarcerated at a TJJD facility. Cottrell is an all-male facility; therefore, no interviews pursuant to this provision were conducted.

(e): TJJD policy requires that if pregnancy results from a sexual assault, the youth is provided timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Additional services provided to youth are included in GAP 380.9195. Cottrell is an all-male facility; therefore, no interviews pursuant to this provision were conducted.

(f): TJJD policy requires TJJD to offer tests for sexually transmitted infections, as medically appropriate, to youth victims of sexual abuse while incarcerated. No incidents requiring these services occurred during the audit period; therefore, the auditor did not review medical records or secondary materials related to this provision.

(g): TJJD policy requires that all treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

(h): TJJD policy requires that TJJD attempts to conduct a mental health evaluation of all known youth-on-youth abusers within 60 days of learning of such abuse history and shall offer treatment when deemed appropriate by mental health care staff. Medical and mental health staff members reported that all youth receive a mental health evaluation during intake and periodically throughout their stay.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall offer medical and mental health evaluations to all residents who have been victimized in a juvenile facility; b) the evaluation and treatment shall include follow-up services, treatment plans, and referrals for continued care if necessary; c) the facility shall provide services consistent with the community level of care; d) resident victims of vaginal penetration shall be offered pregnancy tests; e) if pregnancy results, the victim shall receive access to lawful pregnancy-related medical services; f) resident victims while incarcerated shall be offered tests for sexually transmitted infections; g) treatment shall be provided at no cost to the resident; and h) the facility shall attempt to evaluate all known resident-on-resident abusers within 60 days of learning of such history and offer treatment when deemed appropriate by mental health care staff.

The auditor determined that TJJD policy addresses all elements, which supports compliance with provisions (a) – (h). During interviews, youth confirmed they receive these services, which provided additional support of compliance with these provisions. Cottrell is an all-male facility; therefore, no youth received the services pursuant to provisions (e) and (f). The auditor determined compliance with these provisions based on policy review. Compliance with provision (g) was also based on interviews, during which staff and youth confirmed medical and mental health care services are

provided at no cost. Since the facility exceeds the 60-day requirement of providing additional services, and all youth receive ongoing treatment, the auditor determined compliance with provision (h). Since the facility demonstrated compliance with all provisions, the auditor determined Cottrell meets the requirements of this standard.

Corrective Action: None

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (n)
3. Monthly memos from the Assistant Superintendent

Interviews:

1. Facility Superintendent
2. Compliance Coordinator
3. Incident review team members

Observations: No observations relative to this standard were required.

(a): TJJD policy requires Cottrell to conduct a SARB at the conclusion of every sexual abuse investigation unless the allegation is determined to be unfounded. The team includes managers, supervisors, investigators, and medical and mental health practitioners. The team considers 1) whether the allegation or investigation indicates a need to change policy or practice, 2) whether the incident was motivated by race, ethnicity, gender identity, status or perceived status as LGBTI, gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility motivated the incident, 3) physical barriers that may enable abuse, 4) staffing levels, and 5) whether monitoring technology should be enhanced. Policy requires that following the SARB, Cottrell must implement the review team's recommendations or reasons for not doing so.

As the PAQ and signed and data memos from the Assistant Superintendent for each month of the audit reporting period indicate, no PREA-related incidents occurred, no notifications of the closure of an investigation were received, and no SARBs were conducted.

(b): TJJD policy does not require the review to occur within 30 days of the conclusion of the investigation; however, the PAQ indicated this was the practice. No SARBs were conducted during the audit reporting period; however, facility staff members demonstrated their knowledge of the process.

(c): TJJD policy requires that managers, supervisors, investigators, and medical or mental health practitioners participate in the review. No SARBs were conducted during the audit reporting period, but the Superintendent understood that these members would be present during a review.

(d): SARB forms include discussion topics, which address each of the elements for this provision. The Superintendent, Compliance Manager, and members of the incident review team demonstrated their knowledge of the items that would be considered and provided examples of potential resulting actions. The Superintendent and Compliance Manager stated that no incidents have occurred during the audit reporting period, but described the review process and the actions that each would carry out during and following a SARB.

(e): TJJD policy requires that the facility implement the SARB team's recommendations or document the reasons for not doing so.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the facility shall conduct an incident review at the conclusion of every sexual abuse investigation; b) the review shall be conducted within 30 days of the conclusion; c) the review team shall include upper-level management and input from line supervisors, investigators, and medical and mental health care staff; d) the review team shall consider policy or practice change, potential motivations of the incident, the area where the incidence allegedly occurred, and monitoring

technology, and prepare a report of findings; and e) the facility shall implement recommendations for improvement or document the reasons for not doing so.

The auditor determined TJJD policy addresses all provisions except provision (b). Since no incidents or subsequent SARBs occurred, the auditor relied upon policy, the PAQ responses, and interview responses to determine compliance with provisions (a) – (e). The auditor determined the facility meets the requirements of each provision, and thus meets the requirements of this standard.

Corrective Action: None

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?
  ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?
  ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
  ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (o)
3. Copy of definitions
4. Data collection instrument
5. Documentation of approval by the TJJD Executive Director
6. TJJD website

Interviews: No interviews relative to this standard were required.

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that TJJD collect data for every allegation of sexual abuse at TJJD-operated facilities using a standardized instrument and set of definitions. TJJD also maintains, reviews, and collects data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews. TJJD develops its data collection instrument to include the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U.S. Department of Justice (DOJ). The collection system pulls data from TJJD's database with youth records to include additional information such as youths' age and gender.

(b): TJJD policy requires that TJJD aggregate the data at least once each year. The auditor reviewed the TJJD website and noted that the annual reports were available for consecutive annual surveys of sexual victimization through year 2017, which contains the most current data available.

(d): TJJD policy requires that TJJD maintain, review, and collect data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews.

(e): TJJD policy requires that TJJD obtain incident-based and aggregate data from each residential facility operating under a contract with TJJD. The auditor reviewed the most recent annual report to confirm that sexual abuse data was collected at state-operated and contracted facilities.

(f): TJJD policy does not require the agency to provide all such data from the previous calendar year to the DOJ no later than June 30, but a review of TJJD's website indicated annual Surveys of Sexual Victimization were completed, which indicated this is the regular practice, and the data is provided annually.

Corrective Action: None

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (p)
3. Memorandum that includes annual PREA data
4. Data collection instrument for three consecutive years
5. TJJD website

Interviews:

1. Superintendent
2. Executive Director
3. Compliance Coordinator
4. Compliance Manager

Observations: Staff members assigned to review live video and assigned to dorm control rooms

(a): TJJD policy requires that TJJD review aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. Following this review, TJJD prepares an annual

report of its findings and corrective actions for each facility and the agency as a whole. The TJJD Executive Director indicated her knowledge of the data review and said that she sexual abuse data is assessed so that any problems can be identified. Once identified, she said she looked for any related bigger problem that would indicate whether the problem was isolated or a facility culture issue. To address issues, she said she would assemble a group to begin talking about how to correct the issues.

The Compliance Coordinator said the collected data is reviewed, that she is the only one with access to the final report, that identifying information is removed, and that corrective actions are taken based on the collected data. A memo titled *TJJD PREA Year in Review – CY 2017* to the Executive Director from the Compliance Coordinator includes data for substantiated, unsubstantiated, unfounded, and open investigations regarding youth-on-youth nonconsensual sexual acts, abusing sexual contact, youth-on-youth sexual harassment, and staff sexual misconduct, staff sexual harassment. The memo includes actions taken in response to confirmed cases such as:

- Wearing body-worn cameras at secure facilities
- Utilizing youth safety plans
- Conducting unannounced rounds
- Limiting cross-gender viewing
- Assign seating for youth during transport
- Ensure the zero tolerance and break the silence posters are displayed
- Ensure youth are in their assigned bedroom at bedtime
- Ensure opposite-gender staff announce their presence
- Utilize surveillance video
- Maintaining proper ratios and documenting the justifications of deviations from 1:8/1:16
- Provide medical and mental health care to victims
- Provide training and education including:
    - PREA-related protocols
    - Sexually safe environments
    - Youth training on zero tolerance and reporting options
    - Youth training on rape crisis resources in the community
- Screening for risk
    - Safe housing assessments and reassessments
    - Vulnerability assessments
- Responses following youth reports
    - Monitor for retaliation
    - Increase youth willingness to report with improved culture
    - Conduct SARBs
    - Investigate all allegations

(b): TJJD policy states that, "TJJD reviews aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. Following this review, TJJD prepares an annual report of its findings and corrective actions for each facility and the agency as a whole. The report will be posted on the agency's website." The auditor reviewed the memo described above in provision (a) to ensure the review included a comparison of the previous year's sexual abuse data. The memo compares the years 2014 – 2017 and includes aggregated data for TJJD and contracted

facilities, current and future plans, and proactive steps taken to eliminate sexual abuse and harassment as listed above in subsection (a).

(c): TJJD policy requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities. Although policy does not require the Executive Director to approve the report, documentation of this approval was provided. The TJJD Executive Director said that her designee approves the report.

(d): A review of the posted data indicates TTJD takes appropriate measures to protect specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility. The Compliance Coordinator reported that no information is redacted, because the report never includes identifying personal information on a perpetrator, victim, or witness.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall review and assess the data collected pursuant to Standard 115.387 and prepare a report of findings; b) the report shall include a comparison of the current year's data and corrective actions to prior years and provide the agency's progress in addressing sexual abuse; c) the report shall be approved by the agency head and be made available to the public; and d) the agency may redact material if it presents a clear and specific threat to the safety and security of the facility.

The auditor determined TJJD policy addresses provisions (a), (b), and (d). Additional compliance with provision (a) was based on a review of the corrective and continued actions detailed in the memo. Most actions described in the memo were observed during the facility inspection, which provided additional evidence of compliance with provision (b). The auditor based compliance with provision (c) on interviews, during which the Executive Director stated her designee approves the report before it was posted on the website. During interviews, the Compliance Coordinator stated that no personal information is included in the report, which was confirmed during the auditor's review of the reports, which supports compliance with provision (d). Since the facility demonstrated compliance with each provision, the auditor determined that Cottrell meets the requirements of this standard.

Corrective Action: None

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (o), (p)
3. TJJD website

Interviews:

1. Superintendent
2. PREA Compliance Coordinator

Observations: No observations relative to this Standard were required.

(a): TJJD policy requires that all sexual abuse data is securely retained. The Compliance Coordinator confirmed compliance and stated the data is password protected. The data is derived from the OIG and AID databases, and access to these are strictly limited.

(b): TJJD policy requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities. The auditor confirmed the data is included on the TJJD website.

(c): A review of the published data revealed that TJJD removes all personal identifiers prior to making aggregated sexual abuse data publicly available.

(d): PREA Standard 115.389 requires TJJD to maintain sexual abuse data for at least 10 years after the date of its initial collection, unless Federal, State, or local law requires otherwise. Historical data is available on the website beginning in 2012, which supports compliance with this subsection.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall ensure the data collected pursuant to Standard 115.387 are securely retained; b) the agency shall make the data available to the public; c) the agency removes personal identifiers from the public data; and d) the agency maintains the data for 10 years.

The auditor determined TJJD policy addresses provisions (b) and (c). The auditor visited the agency website to confirm the aggregated data with personal identifiers removed is readily available to the public. Compliance with provision (a) was based on the interview with the Compliance Coordinator who confirmed the data is securely stored on state servers. The agency is required to maintain sexual abuse data for at least 10 years, which demonstrates compliance with provision (d). Since Cottrell demonstrated compliance with all provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this Standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this Standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (q)
3. TJJD website
4. Photographs of audit notice posting
5. Overall documentation uploaded to a secure drive

Interviews: No interviews specific to this standard were conducted

Observations:

1. All areas within the facility

(a): TJJD policy requires that TJJD conduct audits pursuant to the Code of Federal Regulations relating to the PREA (28 CFR 115.401 – 115.405). The TJJD website contains the final PREA reports for state secure, state halfway houses, contract facilities, and county facilities. There are no facilities operated by a private organization on behalf of the agency.

(b): This is the third year of the current audit cycle. During the second year of the cycle, PREA audits were conducted for four of the 13 TJJD-operated facilities.

(h): During the on-site portion of the audit, the auditor conducted a facility inspection and observed all areas inside and outside of the house.

(i): The auditor received documentation relevant to each PREA standard prior to the on-site audit. Additional documents were requested and sent via email or uploaded to the secure drive. During the on-site portion, personnel background checks and youth files were reviewed.

(m): During the facility inspection, the auditor informally interviewed youth and staff in the day area and classroom. Following the inspection and during the second day of the audit, the audit team conducted formal interviews with staff members and youth.

(n): Prior to the on-site audit, notices were posted that included necessary contact information, thus enabling youth to send confidential information or correspondence to the auditor. The auditor did not receive such correspondence.

Summary of Findings:

The auditor assessed TJJD policy and practice against the elements of this standard, which require that: a) during the three-year period starting on August 21, 2013, and each three-year period thereafter, the agency shall ensure each facility is audited at least once; b) during each one-year period, the agency shall ensure that each facility type is audited; h) the auditor shall have access to and observe all areas of the facility; i) the auditor shall be permitted to request and receive relevant documents; m) the auditor shall be permitted to conduct private interviews with residents; and n) residents shall be permitted to send confidential correspondence to the auditor in the same manner as if they were communicating with legal counsel.

Compliance with provision (a) was based on the auditor's review of the TJJD website, which contains links to PREA audit final reports that were conducted beginning in 2014, which evidenced that each facility was audited at least once during the three-year cycle. The auditor relied upon policy and the PREA-related activities included in the annual report to determine compliance with provision (b). Since the auditor team was provided access to all areas within the facility during the facility inspection, compliance with provision (h) was demonstrated. Since the auditor was granted access to and permitted to request and received relevant documents prior to, during, and after the on-site audit portions, compliance with provision (i) was demonstrated. The auditor team was provided private areas in which to conduct interviews with youth, and thus demonstrated compliance with provision (m). The audit notices that were posted throughout the facility prior to the onsite audit enabled youth and staff to correspond with the auditor by including the auditor's contact information; thus compliance with provision (n) was demonstrated. Since the facility complied with each provision, the auditor determined TJJD meets the requirements of this standard.

Corrective Action: None

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.)

  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. TJJD website
2. Final audit reports of TJJD facilities

Interviews: No observations relative to this standard were required.

Observations: No observations relative to this standard were required.

(f): The TJJD website contains prior final audit reports that were posted within 90 days of issuance by the auditor.

Summary of Findings:

The auditor assessed TJJD practice against the elements of this Standard, which require that: f) the agency shall ensure that the auditor's report is published on the agency website or otherwise made readily available to the public.

The auditor determined compliance with this provision by visiting the agency website and confirming previous audit reports are posted; thus the facility meets the requirements of this standard.

Corrective Action: None

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditor must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Nicole Prather August 27, 2019

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.